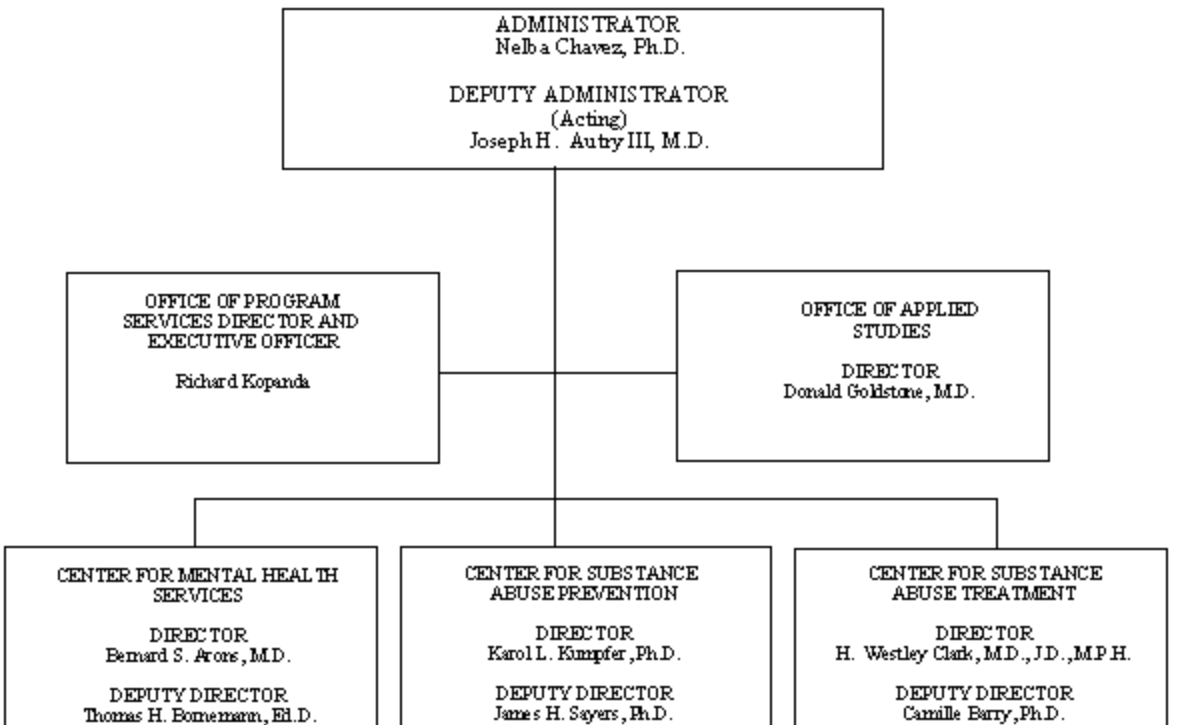
DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration



November 6, 1998

Substance Abuse and Mental Health Services Administration

Appropriation Language

For carrying out titles V and XIX of the Public Health Service Act with respect to substance abuse and mental health services, the Protection and Advocacy for Mentally Ill Individuals Act of 1986, and section 301 of the Public Health Service Act with respect to program management, [$2,488,005,000: Provided, That of the amount provided, $300,000 shall be for the Philadelphia City-wide Improvement and Planning Agency.]1/ $2,726,505,000, *of which* $100,000,000 *shall become available on October 1, 2000 and remain available until September 30, 2001. 2/ (Department of Health and Human Services Appropriation Act, 1999, as included in Public Law 105-277, section 101(f).)*

Explanation of Language Changes

1/ This language is not required . This provision was included in FY 1999 to earmark funds.

2/ This language would authorize the availability of $100,000,000 on October 1, 2000 for the Substance Abuse Block Grant.

Amounts Available for Obligation

	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate
Appropriation:			
Labor/HHS-Annual	$2,147,156,000	$2,488,005,000	$2,626,505,000
Subtotal, adjusted budget authority	2,147,156,000	2,488,005,000	2,626,505,000
Temporary suppl to SABG P.L.104-121.	50,000,000	---	---
Unobligated balance, start of year	295,541	272,429	---
Unobligated balance available, end of year	(272,429)	---	---
Unobligated balance expiring	(3,773,739)	---	---
Offsetting Collections from:			
Federal Sources	20,264,044	22,000,000	22,000,000
Total obligations	$2,213,669,417	$2,510,277,429	$2,648,505,000

Substance Abuse and Mental Health Services Administration
Summary of Changes

2000 Estimate	$2,626,505,000
1999 Appropriation	-2,488,005,000
Net Change	+$138,500,000

	FY 1999 Appropriation		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. Annualization of 1999 pay costs	--	$47,031,000	--	+$1,137,000
2. Within grade pay increases	--	47,031,000	--	+837,000
3. Increase for January 2000 pay raise at 4.4%	--	47,031,000	--	+1,528,000
4. Increased rental payments to GSA	--	4,865,000	--	+229,000
5. Increase in overhead charges	--	53,400,000		+769,000
Subtotal, Built-in Increases	--	---	--	+4,500,000
B. Program:				
1. Targeted Capacity Expansion	--	133,515,000	--	+55,000,000
2. PATH Homeless Formula Grants	--	26,000,000	--	+5,000,000
3. Mental Health:				
a. Mental Health Block Grant	--	288,816,000	--	+70,000,000
4. Substance Abuse:				
a. Substance Abuse Block Grant	--	1,585,000,000	--	+30,000,000
Subtotal, Program Increases	--	---	--	+160,000,000
Total Increases	--	---	--	+164,500,000
Decreases:				
A. Program:				
1. Knowledge Development and Application:				
a. Substance Abuse Prevention -- program reduction	--	78,717,000	--	-26,000,000
Subtotal, Program Decreases	--	---	--	-26,000,000
Total Decreases	--	---	--	-26,000,000
Net Change	--	---	--	+$138,500,000

Substance Abuse and Mental Health Services Administration
Budget Authority by Activity

(Dollars in thousands)

	FY 1998 Actual	FY 1999 Enacted	FY 2000 Request	FY 2000 +/- FY 1999
Knowledge Development and Appl	**$273,421**	**$293,317**	**$267,317**	**-$26,000**
Mental Health (Non-add)	*(57,964)*	*(97,964)*	*(97,964)*	*0*
Substance Abuse Prevention (Non-add)	*(84,321)*	*(78,717)*	*(52,717)*	*-26,000*
Substance Abuse Treatment (Non-add)	*(131,136)*	*(116,636)*	*(116,636)*	*0*
Targeted Capacity Expansion	**$91,411**	**$133,515**	**$188,515**	**+$55,000**
Substance Abuse Prevention (Non-add)	*(66,679)*	*(78,283)*	*(78,283)*	*0*
Substance Abuse Treatment (Non-add)	*(24,732)*	*(55,232)*	*(110,232)*	*+55,000*
High Risk Youth	**6,000**	**7,000**	**7,000**	---
National Data Collection	**18,000**	---	---	---
Office of Applied Studies (Non-add)	*(18,000)*	---	---	---
Children's Mental Health Services	**72,927**	**78,000**	**78,000**	---
Protection & Advocacy	**21,957**	**22,957**	**22,957**	---
PATH Homeless Formula Grants	**23,000**	**26,000**	**31,000**	**+5,000**
Mental Health Block Grant	**275,420**	**288,816**	**358,816**	**+70,000**
Substance Abuse Block Grant	**1,310,107**	**1,585,000**	**1,615,000**	**+30,000**
Program Management 1/	**55,400**	**53,400**	**57,900**	**+4,500**
FTE's	**(549)**	**(574)**	**(565)**	**(-9)**
TOTAL, SAMHSA	**$2,147,643**	**$2,488,005**	**$2,626,505**	**+$138,500**
SSI Supplement to SABG (P.L. 104-121)	**$50,000**	---	---	---
TOTAL, Program Level	**$2,197,643**	**$2,488,005**	**$2,626,505**	**+$138,500**

1/ Includes a transfer of $900,000 for methadone maintenance for FY 1998.

Substance Abuse and Mental Health Services Administration
Budget Authority by Object Class
Substance Abuse and Mental Health Services Adminstration
SALARIES AND EXPENSES
(Dollars in Thousands)

	FY 1999 Appropriation	FY 2000 Estimate	Increase or Decrease
Personnel Compensation:			
Full Time Permanent (11.1)	$36,946	$38,209	$1,263
Other than Full-Time Permanent (11.3)	1,235	1,384	149
Other Personnel Compensation (11.5/11.8)	1,200	1,200	---
Total Personnel Compensation	**39,381**	**40,793**	**1,412**
Personnel Benefits (12.1)	7,610	8,252	642
Benefits to Former Personnel (13.0)	40	45	5
Subtotal Pay Costs	**47,031**	**49,090**	**2,059**
Travel (21.0)	1,199	1,100	(99)
Transportation of Things (22.0)	105	100	(5)
Rental Payments to GSA (23.1)	4,865	5,094	229
Rental Payments to Others (23.2)	40	45	5
Communications, Utilities and Misc. Charges (23.3)	1,401	1,442	41
Printing and Reproduction (24.0)	3,608	3,600	(8)
Consulting Services (25.1)	15,410	15,842	432
Other Services (25.2)	163,613	168,464	4,851
Other Contractual Services (25.0)	101,576	104,575	2,999
Purchases from Gov't Accounts (25.3)	24,085	24,801	716
Supplies and Materials (26.0)	392	350	(42)
GOCO's (25.4)	44	44	---
Subtotal Non-Pay Costs	**108,321**	**111,212**	**2,891**
Total Salaries and Expenses	**$155,352**	**$160,302**	**$4,950**
Equipment (31.0)	1,783	1,500	(283)
Grants, Subsidies, and Contributions (41.0)	2,224,429	2,355,033	130,604
Subtotal Non-pay Costs	**2,440,974**	**2,577,415**	**136,441**
Total	**$2,488,005**	**$2,626,505**	**$138,500**

Significant Items in House, Senate, and Conference Appropriations Committee Reports

1999 House Appropriations Committee Report Language (No. 105-635)

Item: **Violence in schools** -- The Committee is concerned by the recent outbreaks of violence in our Nation=s schools and believes one important tool to address this problem is to improve children=s mental health services. The additional funding for mental health knowledge development and applications will assist schools in identifying and addressing the mental health needs of children and preventing aggressive behaviors. Schools are an ideal location for children=s mental health activities because they facilitate peer-based programs, comprehensive approaches, and access to professionals in a familiar environment where many of the problem behaviors occur. (Page 107)

Action Taken or to be Taken

CMHS has initiated a new program to support the delivery and improvement of mental health services in our nation=s schools. This ambitious program is designed as a comprehensive, interagency collaborative approach with the Department of Education and the Department of Justice to link schools with local and State mental health service providers. School districts will implement a wide range of early childhood development, early intervention and prevention, and mental health treatment services that appear to have the greatest likelihood of preventing violence among children.

Item: **Need for trained health providers --** The Committee is aware of the need for more trained health providers, including social workers, to work with people suffering from HIV/AIDS. The Committee encourages CMHS to consider continued funding for existing grants and contracts previously approved under the current AIDS training program. (Page 107)

Action Taken or to be Taken

CMHS will continue to fund the current HIV/AIDS Education grants and contracts.

Item: **HIV/AIDS mental health services projects** -- The Committee commends CMHS for its commitment in disseminating knowledge gained from the HIV/AIDS Mental Health Services Demonstration projects. The Committee urges CMHS to maintain its support for projects that provide direct mental health services while at the same time using the findings from previous projects to develop new knowledge in this area. (Page 107)

Action Taken or to be Taken

CMHS plans to continue funding in collaboration with HRSA, NIAAA, NIDA, NIMH and CSAT

for the HIV/AIDS Outcome Cost Study begun in FY 1998. This program is based on the findings from the AIDS Demonstration program. The program studies treatment adherence, health outcomes and associated costs in providing mental health services, substance abuse services and primary health care services to people living with HIV/AIDS.

Item: **Impact of managed care on availability of mental health services** -- The Committee is concerned about the impact of managed care on the availability of mental health services to underserved communities. The Committee urges the Administrator to develop standards and guidelines for the delivery of mental health services in managed care entities, including guidelines for cultural competencies, workforce diversity, and collaboration among primary care disciplines. In addition, the Committee believes that the design of curricula and training models to prepare mental health professionals for managed care and other interdisciplinary health care settings merits consideration for standards and guidelines funding. Finally, the Committee encourages CMHS to collaborate with the Health Resources and Services Administration on the development of training protocols for mental health professionals in primary care settings including the linking of health-related agencies with graduate schools for pre-service and continuing education. The Committee requests that SAMHSA report on the status of such efforts at its fiscal year 2000 appropriation hearing. (Page 107)

Action Taken or to be Taken

CMHS is currently pilot testing the cultural competence standards for widespread implementation. Implementation will necessitate training, both pre-service training such as the Minority Fellowship Program and in-service training or continuing education. CMHS will continue to collaborate with HRSA. This program has a training needs assessment to assure quality of MH/SA services for older adults through primary care. We are also collaborating on extending a successful coalition building to improve mental health services for older adults project. This is a critically important foundation for interdisciplinary/academic/community and primary care training.

Item: **Care and treatment for the homeless** -- More needs to be done to provide effective support for communities seeking to develop creative solutions to the problem of care and treatment for homeless individuals with severe mental illnesses. The Committee encourages CMHS to support the Interagency Council on the Homeless and other Federal agencies to address to address this issue. (Page 107)

Action Taken or to be Taken

CMHS continues to be a partner with HUD, NIMH, VA and others on issues facing the homeless and actively participates on the Interagency Council on the Homeless.

Item: **Mental health minority fellowship program** -- The Committee recognizes the role that the

minority fellowship program plays in providing mental health services. The Committee encourages SAMHSA to continue this program through its different centers. (Page 107)
Action Taken or to be Taken

SAMHSA plans to continue support for the Minority Fellowship Program at the same level as FY 1998.

Item: **Assessing quality of patient care** -- ...the Committee is concerned that in order to monitor the quality of care that patients receive, a methodology is needed that will use information from patients and providers to assess the quality of care, while reflecting the full range of clinical complexity, setting and financing and delivery systems that may influence care. Therefore, the Committee expects that SAMHSA will fund data collection, analysis, and reporting systems in order to develop performance measures. These performance measures should use an evidence-based methodology such as those developed by a national medical organization in a scientifically-rigorous manner that will ensure the reliability and validity of the resulting data. The Committee believes that such indicators will also help fulfill the Results Act requirements for assessing outcomes. (Page 110)

Action Taken or to be Taken

SAMHSA has made substantial progress in developing measures and obtaining data to provide baselines and develop performance targets to monitor the quality of services in its programs. These measures are reflected in SAMHSA=s FY 2000 Government Performance and Results Act (GPRA) Performance Plan. Client outcome measures developed in the past year for SAMHSA=s discretionary programs emphasize functional outcomes, such as whether clients are employed or engaged in productive activities, have a permanent place to live in the community, or have involvement with the criminal justice system. Clinical outcomes, such as the absence of substance abuse or the absence of health, behavior, or social consequences from the disease or disorder also are included. Similar types of measures are being implemented for both block grants. Two additional performance measurement development efforts of great significance are SAMHSA=s collaboration with the Office of National Drug Control Policy on the National Drug Control Strategy/Performance Measures of Effectiveness and with other Department of Health and Human Services (HHS) agencies on Healthy People 2010.

SAMHSA has pursued three measurement development efforts in the area of managed care, built around the framework of a 1997 Institute of Medicine (IOM) report. The American College of Mental Health Administrators, with SAMHSA financial and programmatic support, has brought together key stakeholders to reach consensus on core performance measures for mental health and substance abuse. As part of this effort, SAMHSA also has convened The Washington Circle, an expert panel of managed care experts, health services researchers and providers, to guide the process of performance measure development, pilot testing and implementation for substance abuse and managed care. SAMHSA has worked closely with the Health Care Financing Administration

to ensure that standards and guidelines in the Quality Improvement System for Managed Care (QISMC) are sensitive to mental health and substance abuse service systems. SAMHSA works with the three national organizations representing State mental health, substance abuse, and Medicaid directors to identify measures that could be used by States in contracting for Medicaid managed behavioral health care services.

These diverse efforts are arriving at similar conclusions regarding core measures of quality in patient care.

1999 Senate Appropriations Committee Language (No. 105-300)

Item: **Linkages between KDA and State network** -- The Committee urges the agency to establish stronger linkages between KDA programs and the State network through regular consultation and coordination of effort with the State agencies and through other appropriate steps. (Page 147)

Action Taken or to be Taken

Both CSAT=s and CSAP=s Knowledge Development and Application programs represent a comprehensive approach to identifying, disseminating and promoting the adoption of Abest practices@ in the substance abuse treatment system, including States. Consistent with this mission, State input regarding the KDA initiatives is solicited on a regular basis through regional meetings, national conferences and periodic meetings with the National Association of State Alcohol and Drug Abuse Directors (NASADAD). These activities, coupled with Congressional and Departmental initiatives comprise a significant component of the input that both Centers seek from States.

Findings are disseminated to the States through a variety of activities. These include the publication and dissemination of CSAT=s Treatment Improvement Protocols and CSAP=s Prevention Enhancement Protocols, the planned development of grant funding announcements that support the implementation of best practices in State and community systems, and through other dissemination activities. Finally, both Centers utilize KDA based information in delivering technical assistance to State systems.

Additionally, CSAP undertakes several ongoing efforts with NASADAD, including regular Leadership meetings and the Regional National Prevention System meetings, all of which provide opportunities to discuss program plans and draw stronger linkages between our ongoing KDA efforts and State systems and needs. CSAT anticipates focusing its FY 2000 national State Systems Development Conference on best practices, with a specific agenda that will bring the KDA findings to the field. This conference is attended by all of the State agencies responsible for substance abuse treatment as well as providers and other policy makers.

Item: **Mental health/substance abuse services** -- The Committee again restates its belief that mental health and substance abuse services are essential elements of primary care, and its concern about the impact of managed care on access to mental health services, and supports training of behavioral and mental health professionals for work in managed care settings, particularly in rural and underserved communities. The Committee urges the development of standards and guidelines for the delivery of such services in managed care entities, including curricula design and training models. The Committee further encourages CMHS to collaborate with the Health Resources and Services Administration (HRSA) on the development of training protocols for mental health professionals in primary care settings. (Page 147)

Action Taken or to be Taken

Over the past two years, CMHS has developed reports on standards of care, clinical guidelines and provider and system competencies reports. A dissemination and utilization plan is being developed including pilot testing cultural competence standards, and design of curricula and training models to prepare mental health professionals for managed care.

Item: **Funding of interdisciplinary health professions training** -- The Committee is pleased with the successful collaboration between the Center for Mental Health Services and the Bureau of Health Professions in HRSA to fund interdisciplinary health professions training projects, including training of behavioral and mental health professionals, for practice in managed care/primary care settings and urges that this joint effort be continued. The Committee encourages both agencies to develop technical assistance for use in health professions training programs for the purpose of enhancing primary care interdisciplinary models of practice. These efforts should be focused upon rural native populations that are at-risk for the problems most encountered by these health professionals. (Page 148)

Action Taken or to be Taken

CMHS is collaborating with HRSA to continue an initiative on multi-disciplinary training of mental health professionals in primary care settings. CMHS also continues to support the Minority Fellowship Program which facilitates the entry of ethnic minority students into mental health careers and increases the number of psychiatrists, psychologists, social workers and nurses trained to teach, administer and provide direct mental health and substance abuse services to ethnic minority groups. With a program focused on underserved minority populations of Native Americans, Asian Pacific Americans, African Americans and Hispanic Americans, the Minority Fellowship Program (MFP) encourages training to meet personnel shortages in rural and urban minority communities.

Item: **Psychological effects of torture** -- The Committee notes that survivors of torture from abroad represent a significant element in many of our communities. For many survivors, the psychological effects of torture can be crippling, but with treatment, they can become contributing members of their communities. For these reasons, the Committee recommends that the Center for Mental Health Services provide fudging for research, training, and proper treatment for victims of torture. (Page 148)

Action Taken or to be Taken

Through an intra-agency agreement with the Office of Refugee Resettlement, CMHS staff will develop a directory of service providers and resources for treatment of survivors of torture, develop a clinical training manual for primary care providers on the recognition, assessment, and referral of survivors of torture, and develop a world wide web site for information and links related to survivors of torture.

Item: **Evidence-based methodology** -- ... The Committee encourages the agency to create an evidence-based methodology developed by a national medical organization in a scientifically rigorous manner and based on information from patients and providers. This methodology will allow the agency to assess the quality of care while reflecting the full range of clinical complexity, setting, and financing and delivery issues that may influence that care. (Page 148)

Action Taken or to be Taken

CMHS continues to develop its Consumer-Oriented Report Card for Managed Behavioral Healthcare. Currently, 40 State Mental Health agencies have grants to test this report card. In addition, CMHS is working with the Practice Guideline Coalition, representatives of the mental health disciplines, and consumer and family groups to define the issues in clinical and system practice guidelines and to develop appropriate, consensus-based courses of action. CMHS is also developing an information prototype that will include measures for guidelines, outcomes, and report cards.

Item: **Training projects** -- The Committee urges the agency to fund training projects that foster cultural competencies, a diverse work force, collaboration among disciplines, and the use of interdisciplinary service delivery models, especially in rural areas such as Hawaii, where the cultural diversity factors predominate. (Page 149)

Action Taken or to be Taken

CMHS is collaborating with HRSA to continue an initiative on multi-disciplinary training of mental health professionals in primary care settings. CMHS also continues to support the Minority Fellowship Program which facilitates the entry of ethnic minority students into mental health careers and increases the number of psychiatrists, psychologists, social workers and nurses trained to teach, administer and provide direct mental health and substance abuse services to ethnic minority groups. With a program focused on underserved minority populations of Native Americans, Asian Pacific Americans, African Americans and Hispanic Americans, the MFP encourages training to meet personnel shortages in rural and urban minority communities.

Item: **Substance abuse among homeless** -- The Committee is concerned that substance abuse among the Nation=s homeless population remains a serious problem that receives limited attention. The Committee encourages the Department to address the unique needs and life circumstances of homeless people through a targeted treatment program. (Page 151)

Action Taken or to be Taken

CSAT and CMHS are planning to co-fund a grant program in FY 1999 with an emphasis on short-term interventions and appropriate follow-up targeted to homeless mothers with psychiatric and/or

substance use disorders. The goals of this program include movement out of homelessness, stability in housing placement, decreased alcohol and drug use, and improvement in mental health and family functioning.

In addition, the Targeted Treatment Capacity Expansion Program, which CSAT plans to reissue in 1999, provides a vehicle for jurisdictions in which substance abuse treatment for homeless populations is a serious need to seek support to address the problem.

Item: **Substance abuse among youth --** The Committee is concerned about the growing problem of substance abuse among children and teenagers. The Committee encourages the Department to develop and disseminate new treatment models for adolescents. These efforts should include a focus on effective school-based intervention. (Page 151)

Action Taken or to be Taken

In FY 1998, CSAT began a program to identify Exemplary Treatment Models for Adolescents. Five grants were awarded, designed to evaluate those regimens of care which appear to be exemplary and determine their usefulness for further replication and dissemination. CSAT plans to expand the program in FY 1999, making 8-12 new awards including some focusing on school-based interventions. In addition, a series of meetings were held late in 1998 with community representatives (i.e., community leaders, educators, parents, youth, researchers) in an effort to determine what is happening with youth, ages 9-12, and to gather input for action to further address treatment issues for this population.

In FY 1998, CSAT began a collaborative effort with the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The purpose of this program is to contribute to the identification and development of efficacious treatment interventions for adolescent alcohol abusers and alcoholics. In addition, projects will be identifying, developing and/or testing screening and diagnostic instruments for use with this population.

Item: **Substance abusing youth at risk --** The Committee recognizes that substance abusing youth are at a high risk for involvement in the juvenile justice system. Therefore, the Committee encourages the Department to support the development of models that foster linkages between school-based and juvenile justice interventions. Some promising approaches that warrant further testing include juvenile assessment centers, truancy interventions, mentoring, family empowerment, and juvenile drug courts. (Page 151)

Action Taken or to be Taken

In FY 1998, CSAT began a program to identify Exemplary Treatment Models for Adolescents. Five grants were awarded, designed to evaluate those regimens of care which appear to be

exemplary and determine their usefulness for further replication and dissemination. CSAT plans to expand the program in FY 1999, making 8-12 new awards. One planned target population is adolescents involved with the juvenile justice system.

Item: **Prevention model --** The Committee also provides $7,000,000 for the purpose of making grants to public and nonprofit private entities for projects to demonstrate effective models for the prevention, treatment, and rehabilitation of drug abuse and alcohol abuse among high risk youth, as authorized by section 517 of the Public Health Service Act as amended. The Committee is highly concerned about the extent of substance abuse among high risk youth. This population is vulnerable to initiating criminal activity against people and property, especially following the acute and chronic use of illicit substances and the abuse of alcohol. These grants are intended to strengthen local capabilities in confronting the complex interrelationships between substance and alcohol abuse and other activities that may predispose young individuals toward criminal, self-destructive, or antisocial behavior. (Page 152)

Action Taken or to be Taken

CSAP=s Project Youth Connect is targeted toward high-risk youth, in particular, those youth who are at high risk for becoming substance abusers and/or involved in the criminal justice system. The program is designed to prevent or reduce substance abuse or delay its onset in youth (9- to 15-years old) by improving: school bonding and academic performance; family functioning and overall life management skills. The program utilizes two intervention strategies: 1) Youth Only Model where interventions include academic support, tutorial assistance, individual/group counseling, conflict resolution, problem solving, peer resistance behavior, violence prevention activities, substance abuse prevention, alternative/ recreational activities, and community service activities, and 2) Youth/Family Model which include the interventions from the youth only models as well as a family component which includes parent effectiveness training, parent support groups, family bonding activities (picnics, family outings), support to parents in conducting school conferences, and support to other siblings in the family.

CSAP has funded 15 projects under this program. Examples of programs funded to date include a Philadelphia, PA, program which targets 120 low income African American middle school youth who have been bystanders to serious violence in their home, school, or community, and/or who may have been directly affected by violence; a program in Northern Colorado which is working with Hispanic, Mexican American and European Americans ages 11-14 in two middle schools to improve academic performance, school bonding and life management skills among high risk youth; a program in St. Louis, MO., which is working with sixth graders from severely distressed neighborhoods in the city; and a program that is working with high-risk Chinese and Vietnamese immigrant youth from primarily low-income families with limited English proficiencies from areas around and within Los Angeles, CA.

1999 Conference Report Language (No. 105-825)

Item: **Youth mentoring program** -- The conference agreement includes bill language identifying $300,000 for the Philadelphia City-Wide Improvement and Planning Agency for a youth mentoring program. (Page 1280)

Action Taken or to be Taken

CSAP awarded a grant to the Philadelphia City-Wide Improvement and Planning Agency on January 7, 1999.

Item: **Violence in schools** -- There are concerns about the recent outbreaks of violence in our Nation=s schools and it is believed that one important tool to address this problem is to improve children=s mental health services. This additional funding will assist schools in identifying and addressing the mental health needs of children and preventing aggressive behaviors. Schools are an ideal location for children=s mental health activities because they facilitate peer-based programs, comprehensive approaches, and access to professionals in a familiar environment where many of the problem behaviors occur. It is intended that SAMHSA will collaborate with the Department of Education to develop a coordinated approach. (Page 1281)

Action Taken or to be Taken

CMHS has initiated a new program to support the delivery and improvement of mental health services in our nation=s schools. This ambitious program is designed as a comprehensive, interagency collaborative approach with the Department of Education and the Department of Justice to link schools with local and State mental health service providers. School districts will implement a wide range of early childhood development, early intervention and prevention, and mental health treatment services that appear to have the greatest likelihood of preventing violence among children.

Item: **Funding of integrated service delivery system** -- The conference agreement provides $2,000,000 from the Center for Mental Health Services KDA program and $3,000,000 from the Center for Substance Abuse Treatment KDA program for a joint award to fund the development of an integrated service delivery system in the State of Alaska to provide both mental health and substance abuse treatment services. (Page 1281)

Action Taken or to be Taken

CSAT and CMHS are collaborating to provide funding to Alaska for the development of a community model for treating people with co-occurring mental and substance abuse disorders. Preliminary discussions have been held with State representatives, as well as a review of the CSAT

Target Cities model of an integrated system as a possible model for this effort . That model includes a management information system, centralized referral, and case management services.

Item: **Assistance to rural areas in Alaska --** The conference agreement provides $1,000,000 for assistance to rural areas in Alaska to support the expansion of services for women and children as part of the Targeted Capacity Expansion Program. (Page 1281)

Action Taken or to be Taken

Three Targeted Treatment Capacity Expansion grants were awarded to Alaska in late September, 1998. In FY 1999, CSAT will continue these grants, as well as work with State representatives to provide technical assistance as needed. Funds will also be set aside to support additional Targeted Treatment Capacity Expansion as needed for this population.

Item: **HIV/AIDS funding for minority activities --** The conference agreement provides $22,000,000 in additional, targeted funding to compliment existing and previously planned HIV/AIDS minority activities to strengthen abuse treatment and prevention programs that include an HIV component. These funds should also be used to address the HIV epidemic in the territories, such as in the Virgin Islands where, for example, the HIV/AIDS case rate is more than twice the national case rate of 24.1 per 100,000. (Page 1281)

Action Taken or to be Taken

Of the $22 million, $16 million was provided to CSAT and $6 million to CSAP. CSAT will utilize $16 million to augment, expand and enhance substance abuse treatment services that include an HIV component. Grants awarded will be restricted to metropolitan areas with AIDS case rates of 25 per 100,000 or higher and States with AIDS case rates of 10 or more per 100,000 (as reported in the CDC=s HIV/AIDS Surveillance Report). These funds will be earmarked for comprehensive substance abuse treatment programs for the following minority populations at risk of contracting or living with HIV: substance abusing African American and Hispanic women and their children; substance abusing African American and Hispanic adolescent boys and girls; and substance abusing African American and Hispanic men (including self-identified homosexual and bisexual men).

The $6 million in prevention will be used by CSAP to undertake a major Substance Abuse and HIV/AIDS Prevention for Youth and Women of Color Initiative focuses on providing HIV/substance abuse prevention services to African American and Hispanic youth and women, with a particular focus on designated hard-hit communities. A major component of this initiative is a Substance Abuse/HIV Prevention Targeted Capacity Expansion program which provides funds to community-based organizations, Historical Black Colleges and Universities, Hispanic Colleges and Universities, Faith communities, and other coalitions and/or partnerships for the purpose of

strengthening the integration of HIV and substance abuse prevention services at the local level and increasing the provision of integrated services to African American and Hispanic youth and women. The HIV/AIDS initiative will also work with CSAP=s Centers for the Application of Prevention Technology (CAPTs) to enable them to integrate HIV prevention into their substance abuse prevention materials and curricula. It will also help build capacity within the CAPTs to provide training and technical assistance to community based organizations and other providers in the hardest hit communities. Finally, the HIV/AIDS initiative will partner with national organizations in several key areas, including accessing and retaining minority youth and women in prevention programs and ensuring the applicability and feasibility of proposed community programs.

Substance Abuse and Mental Health Services Administration
Authorizing Legislation
(continued)

	FY 1999 Amount Authorized	FY 1999 Appropriation	FY 2000 Amount Authorized	FY 2000 Estimate
Unfunded Substance Abuse Activities:				
a. Workplace & Small Business (Prevention) PHSA Section 518 (e)	Expired	---	Expired	---
b. Outpatient Treatment Programs for Pregnant and Postpartum Women: PHSA Section 509 (a)	Expired	---	Expired	---
Mental Health Services for Children: PHSA Section 565	Expired	$78,000,000	Expired	$78,000,000
Protection and Advocacy: P.L. 102-173, Section 117	Expired	22,957,000	Expired	22,957,000
PATH Formula (Homeless): PHSA Section 535 (a)	Expired	26,000,000	Expired	31,000,000
Mental Health PPBG: PHSA Section 1920 (a)	Expired	288,816,000	Expired	358,816,000
Substance Abuse Block Grant: a. Block Grants for Prevention and Treatment of Substance Abuse: PHSA Section 1935 (a)	Expired	1,585,000,000	Expired	1,615,000,000
Buildings and Facilities: Public Law 98-621	Indefinite	---	Indefinite	---
Program Mangement: a. Program Management - PHSA Section 301; Section 501	Indefinite	51,599,000	Indefinite	56,364,000
b. SEH Workers' Comp. Fund - P.L. 98-621	Indefinite	1,801,000	Indefinite	1,536,000
Total, SAMHSA		**$2,488,005,000**		**$2,626,505,000**
Total Program Level		**$2,488,005,000**		**$2,626,505,000**
Total Appropriations Against definite authorizations		---		---

Substance Abuse and Mental Health Services Administration
Appropriations History

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
Alcohol, Drug Abuse, and Mental Health Administration				
1988	1,042,873,000	503,034,000 1/	1,469,313,000	1,373,727,000
1989	1,504,413,000	507,594,000 2/	1,583,191,000	1,562,712,000
1989 Supplmntl	---	---	---	283,000,000
1990	1,738,716,000	1,917,162,000	2,005,448,000	1,926,818,000 3/
1990 Sec 518 Red.	---	---	---	-1,135,000
1990 (DOT Appr)	300,000,000	---	---	727,000,000
1990 Sequester	---	---	---	-26,745,000
1991	2,831,511,000 4/	2,825,891,000 3/5/	3,000,283,000 3/	2,966,898,000 3/
1991 Sec 514 Red.	---	---	---	-77,039,000
1991 Sequester	---	---	---	-38,000
1992	3,048,328,000 6/	2,917,742,000 6/	3,175,832,000	3,081,119,000 7/
1992 Sec 513, Sec 214 Red.	---	---	---	-8,389,000
1993	3,241,159,000 8/	3,099,902,000 8/	n.a.	n.a.
Substance Abuse and Mental Health Services Administration				
1993 9/	2,037,928,000 8/	1,942,417,000 8/	2,049,609,000 8/	2,023,524,000 10/
1993 Sec 216, 511, 513 Red.	---	---	---	-18,721,000
1994	2,153,480,000 11/	2,057,167,000	2,119,205,000 12/	2,125,178,000 13/
1995	2,365,874,000 14/	2,166,148,000	2,164,179,000 15/	2,181,407,000 16/
1995 Red. P.L.103-333	---	---	---	-33,000
1995 Red. P.L. 103-133	---	---	---	-44,000
1995 Resc. P.L. 104-19	---	---	---	-662,000
1996	2,244,392,000	1,788,946,000	1,800,469,000 17/	1,854,437,000 18/
1997	2,098,011,000	1,849,946,000	1,873,943,000	2,134,743,000
1997 Red.P.L. 104-208	---	---	---	-362,001
1997 Red. P.L. 104-208	---	---	---	-69,000
1997 Advance Appro. P.L.104-121	---	---	+50,000,000	19/

Substance Abuse and Mental Health Services Administration
Appropriations History (Continued)

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1998	2,155,943,000	2,151,943,000	2,126,643,000	2,146,743,000 19/
1998 Advance Appro. P.L. 104-121		---	---	+50,000,000 20/
1999	2,279,643,000	2,458,005,000	2,151,643,000	2,488,005,000
2000	2,626,505,000	---	---	---

FOOTNOTES:

1/ Includes $50,700,000 for the Homeless Act.
2/ House did not consider the NIDA and NIAAA research, research training, and direct operation, demonstration programs, Protection and Advocacy, and Grants to States, as they lacked authorizing legislation.
3/ Excludes advance funding for Homeless.
4/ Includes $7,359,000 in 1991 Advance Funding for Homeless.
5/ House did not consider research training Community Support program; and mental health prevention demonstrations program as it lacked authorizing legislation.
6/ Excludes $31,000,000 proposed to be transferred from the Office of National Drug Control Policy (ONDCP) Special Forfeiture Fund.
7/ Excludes $19,000,000 transferred from the Special Forfeiture Fund.
8/ Excludes $34,701,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
9/ FY 1993 Budget Estimate to Congress and House Allowance represent comparable funding levels based on the 1992 ADAMHA Reorganization Act as identified in Conference Report.
10/ Excludes $33,701,000 transferred from the ONDCP Special Forfeiture Fund.
11/ Includes $115,000,000 Presidential Investment.
12/ Excludes $35,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
13/ Excludes $25,000,000 transferred from the ONDCP Special Forfeiture Fund.
14/ Excludes $45,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
15/ Excludes $25,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund.
16/ Excludes $14,000,000 proposed to be transferred from the ONDCP Special Forfeiture Fund. Reflects $44,000 in SLUC and $33,000 in performance awards reductions mandated by the appropriation bill and a rescission in the amount of $662,000.
17/ Includes $200,000,000 proposed transfer from the Safe and Drug Free Schools Act program of the Dept of Education for youth substance abuse prevention programs in schools and communities.
18/ A regular 1996 appropriation for this amount was not enacted.
19/ Advance appropriation P.L. 104-121 from Social Security Administration to Substance Abuse Block Grant.
20/ It does not include $900,000 for Methadone Maintenance

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Substance Abuse and Mental Health Services Administration
A. General Statement/Overview
(Dollars in thousands)

	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Increase or Decrease
Knowledge Development and Application	**$273,421**	**$293,317**	**$267,317**	**-$26,000**
Targeted Capacity Expansion	**91,411**	**133,515**	**188,515**	**+55,000**
High Risk Youth	**6,000**	**7,000**	**7,000**	**---**
National Data Collection	**18,000**	**---**	**---**	**---**
Children=s Mental Health Services	**72,927**	**78,000**	**78,000**	**---**
Protection & Advocacy	**21,957**	**22,957**	**22,957**	**---**
PATH Homeless Formula Grants	**23,000**	**26,000**	**31,000**	**+5,000**
Mental Health Block Grants	**275,420**	**288,816**	**358,816**	**+70,000**
Substance Abuse Block Grant	**1,310,107**	**1,585,000**	**1,615,000**	**+30,000**
Program Management	**55,400**	**53,400**	**57,900**	**+4,500**
TOTAL, SAMHSA	**$2,147,643**	**$2,488,005**	**$2,626,505**	**+$138,500**
SSI Supplement to SABG (P.L. 104-121)	**50,000**	**---**	**---**	**---**
TOTAL, Program Level	**$2,197,643**	**$2,488,005**	**$2,626,505**	**+$138,500**

SAMHSA=s FY 2000 budget submission consolidates budget narrative and the GPRA Performance Plan into a single document. The FY 2000 budget narrative includes program and performance information on newly proposed and newly initiated programs. The budget narrative also includes program descriptions of significant ongoing SAMHSA programs.

The GPRA performance plan consists of two parts. The first sets out the Agency-level performance plan, which explains agency-level measures and core measures that are to be applied, to the extent possible, to all programs. The second sets out component performance plans. The component performance plans include performance measures and targets, and baseline and other data, for ongoing block, formula, and other programs, for selected Knowledge Development and Knowledge Application programs, and for key data initiatives.

Agency Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA) was created on October 1, 1992. The mission of the agency is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses. Individuals with mental illnesses and substance abuse encounter special problems in obtaining care, despite the prevalence and cost of these illnesses. For individuals with health insurance, benefits nearly always are limited relative to those for other illnesses. For those without insurance, some individuals receive excellent care in public sector systems. Others may have access only to

ineffective services or to no services at all. SAMHSA has an essential role in assuring the provision of quality services in these areas of health.

Prevalence and Costs

The 1991 National Comorbidity Survey (NCS) estimated that 27.6 percent of the population age 15-54 had a mental disorder. By 2020, the World Health Organization projects that depression will become the second leading cause of disability in the world, exceeded only by heart disease. Twenty percent of children and adolescents are estimated to have a diagnosable mental, emotional, or behavioral problem. These problems can lead to school failure, alcohol or other drug use, violence, or suicide (Brandenberg, 1990). Suicide is the third leading killer of young people between the ages of 15 and 24. Despite the large prevalence of mental disorders, according to the Institute of Medicine, only 10 to 30 percent of individuals who need mental health services receive them.

SAMHSA=s 1996 National Household Survey on Drug Abuse (NHSDA) indicates that 17.8 percent of the population age 12 and older abuse alcohol, illicit drugs, or both. Approximately 15.5 percent abused alcohol in the past month. Some 100,000 people die each year in the United States as the result of alcohol alone. NIDA=s 1996 Monitoring the Future data indicate that 37 percent of boys and 24 percent of girls in the 12th grade participate in binge drinking. The 1996 NHSDA estimated that 6.1 percent of the population, but 20 percent of those age 18-20, used an illicit drug in the past month. About 18.3 percent of youth ages 12 to 17 years used tobacco in the past month. The U.S. is approaching a new record in the number of new marijuana users, and there are now more new heroin users than ever before. However, only 37% of those who critically need substance abuse treatment receive it.

According to the NCS, 4.7 percent of the population had both a mental disorder and substance abuse/dependence. Among those with an alcohol disorder, 37% also experience a mental disorder. Over a lifetime, the vast majority (79 percent) of mental disorders appear to be comorbid illnesses. The data also suggest that the major economic and social burdens of psychiatric disorders are likely concentrated in those who experience significant comorbidity.

The costs of mental disorders and substance abuse, particularly the indirect costs, are enormous. In 1994, the total costs of mental illness, which includes anxiety disorders, schizophrenia, affective and other disorders, were $204.4 billion.[1] Direct treatment costs were $91.7 billion or 45 percent of the total. Non-treatment costs, such as lost or reduced earnings, and those associated with crime and incarceration, social welfare administration, and family care, accounted for the remainder. In 1995, the total costs for alcohol

[1] Source: Rice DP (1997): Costs of Mental Illness (Unpublished Data). The 1994 estimates are projections from basic conceptual and analytic work done under contract with the Alcohol, Drug Abuse and Mental Health Administration and presented in Rice DP, Kelman, S, Miller LS, Dunmeyer S (1990): The Economic Costs of Alcohol and Drug Abuse, and Mental Illness: 1985: DHHS Publication No. (ADM) 90-194. The 1994 costs were based on socioeconomic indexes applied to the 1985 cost estimates by Dorothy Rice.

abuse were estimated at $166.5 billion and for drug abuse were estimated at $109.8 billion, for a combined total of $276.4 billion[2]. 12% or $34.4 billion were for direct treatment costs. The remaining were non-treatment costs. For example, it costs every man, woman, and child in the United States nearly $1,000 annually to cover the costs of health care, additional law enforcement, motor vehicle crashes, crime, and lost productivity due to substance abuse (Merrill et el., 1993).

With increased support of prevention, early intervention, and treatment services, costs can be reduced. SAMHSA=s contributions to the substance abuse and mental health fields depend upon maintaining an array of programs and mechanisms for addressing service needs.

Long-Term Policy Goals

Three long-term policy goals, for which measures are being implemented, summarize SAMHSA=s fundamental mission:

- Support and contribute to the improvement of community-based systems of mental health care to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious emotional disturbances

- Educate and enable America=s youth to reject illegal drugs as well as underage use of alcohol and tobacco

- Assist States and communities by supporting and helping to improve their substance abuse prevention and treatment efforts

SAMHSA has been a key participant in Healthy People 2000/2010, coordinated by the Department of Health and Human Services (HHS), and in the National Drug Control Strategy/ Performance Measures of Effectiveness effort, coordinated by the Office of National Drug Control Policy (ONDCP). SAMHSA=s long-term policy goals directly support these broader efforts, as well as the goals and objectives of the HHS Strategic Plan.

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[2] Source: Harwood HJ, Fountain D, Livermore G (1998): The Economic Costs of Alcohol and Drug Abuse in the United States, 1992: National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism. Preprint Copy. The 1995 costs were based on socioeconomic indexes applied to the 1992 cost estimates by Harwood et al.

Program Goals

SAMHSA=s program structure consists of nine budget activities. These activities include block and formula grants to assure services availability; discretionary grants to meet needs for targeted services; grants for knowledge development and knowledge application activities; and activities to collect and analyze data and to support data and other infrastructure needs.

This year, SAMHSA and the Centers developed four programmatic goals which summarize the purpose of these programs. The goals encompass all of SAMHSA=s budget activities.

- Bridge the gap between knowledge and practice: Activities in support of this goal develop, test, and implement knowledge gained in research settings in actual service settings, and are supported by Knowledge Development and Application and High Risk Youth funds.

- Promote the adoption of best practices: Activities in support of this goal encourage the adoption of best practices by States, local communities, and providers, and are supported by Knowledge Development and Application funds.

- Assure services availability/ meet targeted needs: Activities in support of this goal provide direct support for services, either through support to implement needed services within a community through discretionary grants or, more broadly, through block and formula grants to States. These activities are supported by six budget activities: the two Block Grant programs for mental health and for substance abuse prevention and treatment; Targeted Capacity Expansion; the Children=s Mental Health Program; and two mental health formula grant programs, PATH and Protection and Advocacy.

- Enhance service system performance: Activities in support of this goal support primary data collection and reporting, data infrastructure development, and other infrastructure needs, and are supported by National Data Collection funds (in years when funds are appropriated) and by 5 percent set-asides from the two Block Grants.

Not all program areas are emphasized in any single year=s budget submission. For example, no new funding is requested for FY 2000 for Programmatic Goal and activities. This varying emphasis will be reflected in each year=s budget narrative and GPRA performance plan.

Core Client Outcome Measures

SAMHSA has proposed a set of core client outcome measures, to be collected across all SAMHSA programs for which these outcomes are an appropriate indicator of performance. SAMHSA is requesting approval in FY 1999 from OMB to collect the data in all discretionary programs to which these measures apply.

Additional GPRA Performance Plan Improvements

- Mental health performance indicators have been developed by SAMHSA and the States. These indicators have now been piloted through programs funded by CMHS and have been cleared by OMB for voluntary collection of data through the FY 1999 and subsequent Community Mental Health Services Block Grant applications.

- Substance abuse treatment indicators have been developed by SAMHSA and the States. SAMHSA will request clearance from OMB for voluntary collection of related data through the FY 2000 and subsequent SAPT Block Grant applications by mid-1999.

- Measures that will yield more valuable performance information have been added to the FY 2000 plan or substituted for certain measures in the FY 1999 plan.

Summary of Budget Request

The FY 2000 budget request for the Substance Abuse and Mental Health Services Administration (SAMHSA) is $2.6 billion, an increase of $138,500 or 5.6% over the comparable 1999 appropriation. The request builds upon ongoing program initiatives, and proposes new or expanded efforts in the key areas of mental health services, Targeted Capacity Expansion, HIV/AIDS, and the increased understanding of service delivery systems. The latter includes youth access to and abuse of alcoholism; issues of violent behavior as they relate to women and women=s services; bioterrorism; strengthening families to resist substance abuse; and similar areas of importance to the Nation. SAMHSA will continue its leadership role in focusing attention on service issues of greatest concern, and achieving consensus on needed improvements in service quality and availability.

The majority of the requested increase ($100 million) is directed to the two SAMHSA Block grant programs, with $70 million of this amount providing a 24.2 percent increase in the Mental Health Services Block Grant. This reflects the high priority accorded expanding service availability through continuing partnerships with the States. State allocations will be based on current statutory authority, using wage data for nonmanufacturing service providers. An additional $100 million is requested as an advanced FY 2001 appropriation increase for the Substance Abuse Prevention and Treatment (SAPT) Block Grant. These funds are requested in advance for two purposes, to secure an advance commitment to continuing efforts to close the substance abuse treatment gap, and to ensure that federal assistance to States in addressing drug problems is available for their use as soon as the fiscal year begins.

The FY 2000 request includes an increase of $55 million for a new program and line item, Targeted Capacity Expansion. This activity includes certain of the substance abuse efforts formerly budgeted within the Knowledge Development and Application (KDA) program. They have been separately identified

because, while related to knowledge application, capacity expansion services have as their goal meeting well-defined needs which are emerging in nature, population-based, limited geographically, or otherwise not optimally addressed through formula allocations to States. Targeted service capacity is generally time-limited, working in conjunction with Block Grant resources to address community needs. Examples include the new HIV/AIDS programs in minority communities; State Incentive Grants for substance abuse prevention; and Targeted Treatment Capacity Expansion focused on treatment needs, such as methamphetamine abuse.

Separate funding is not requested for National Data Collection, consistent with the congressional directive that resources for the expanded Household Survey on Drug Abuse derive from the Block Grant set-asides rather than a separate program. Other set-aside projects have been scaled back or eliminated to accommodate higher Survey costs. Fiscal year 2000 represents the second year in which the expanded Survey will collect State-level data on alcohol and drug abuse, tobacco use by minors and brand preference, and substance abuse co-occurring in combination with mental health problems.

National Priority on Mental Health Services

A significant Administration priority in the FY 2000 budget request is the need to bridge the significant gap between the mental health needs of Americans, and their present ability to access high quality care. The Nation=s mental health system is in fact undergoing significant change as State-level health care reforms, the growth of managed care coverage, welfare reform, and similar issues impact public sector and community-based services. Programs of the Center for Mental Health Services (CMHS) play an important role in understanding these changes, ensuring service system responsiveness, and filling gaps in the availability of community-based services.

This will be achieved in FY 2000 through a modest increase in the Mental Health Block Grant and the Projects for Assistance in Transition from Homelessness (PATH) formula grant programs. Strong program efforts will be continued in the area of children=s mental health and mental health/violence in schools. While the proposed Block Grant increase is the largest ever recommended for this program, it is important to note there has been no increase in the block grant for approximately 5 years. States will receive increases averaging over 24 percent to expand community-based care in such areas as:

- Allowing mentally ill individuals to function within their communities, rather than residing in inpatient institutions;

- Ensuring post-incarceration services are available to individuals who are mentally ill and released from local jails and prison systems;

- Providing an extensive array of community services for children with serious emotional illnesses, such as case management, support services, day treatment, and crisis services;

- Supporting youth suicide prevention programs; and

- Responding to the growing problem of persons with both mental health and substance abuse disorders.

Complementing this increase in mental health care will be a 19.2 percent increase in State allocations to provide services to homeless individuals with severe mental illness, or those who are at high risk for becoming homeless. These individuals require outreach, referrals for mental health and primary health care, rehabilitation, and similar support to improve their health and functional outcomes. The number of clients reached through PATH-supported programs, which receive matching funds from the States, will increase to 115,000 in FY 2000.

Two other extremely important programs focused on children=s mental health needs round out the mental health service effort. In FY 1999, $40 million was appropriated to initiate mental health service programs in our Nation=s schools, addressing in particular those students at risk for violent behavior. SAMHSA is working with the Departments of Education and Justice to help school districts implement community-based programs which incorporate such services as safe school policies, prevention and early intervention, and mental health treatment services. Both this program and the Children=s Mental Health Service Program will be continued in FY 2000 at the increased 1999 level. The Children=s Mental Health Program has demonstrated significant improvements for children after six months of service, including better school grades; fewer school absences; fewer contacts with law enforcement agencies; more stable living arrangements; and, most importantly, marked reductions in children=s functional impairment.

Taken together, these program comprise a much more comprehensive and substantially increased mental health service agenda than that pursued only two years ago. The relationship of these services to the development of new knowledge, described below, is integral to CMHS= effectiveness in improving the Nation=s mental health service system.

Addressing Gaps in Substance Abuse Services

Problems facing the substance abuse service system are similar to those of mental health: a rapidly changing environment, insufficient prevention programs, reduced financing and service gaps, and lack of adequate services for targeted populations. In conjunction with goals of the National Drug Control Strategy, SAMHSA has undertaken four initiatives directly responsive to these concerns. They include:

- Initiation of a Targeted Treatment Capacity Expansion program, and its increase for FY 2000;

- Through Targeted Capacity Expansion (TCE), increasing HIV/AIDS services for drug treatment and prevention will be available in minority communities;

- Continued growth of State service programs through the SAPT Block Grant, building on the 1999 increase; and

- Expansion of the State Incentive Grant prevention program to four new States.

The FY 2000 budget request adds $55 million for treatment expansion targeted to the Nation=s greatest needs, with emphasis on cities, counties and rural areas, doubling the size of the program from 1999 levels. Over 22,000 more clients in serious need of treatment will be able to receive high quality services, ensuring effective outcomes through integral program evaluation. Approximately 60-90 new awards will be made to government units to target regionalized patterns of drug abuse, the unique needs of metropolitan areas, services for substance abusing women and their children, needs of rural and Native American communities, and similar areas where services are substantially lacking.

Nowhere is this need more evident than in HIV/AIDS prevention and treatment services available in minority communities. In 1999, both CSAP and CSAT will award new TCE grants to address the virtual HIV/AIDS epidemic recently identified in African American and Hispanic communities, and particularly affecting women injecting drugs. Community-based organizations, minority institutions of higher education, the faith community and others will be engaged in developing HIV prevention strategies and enhancing substance abuse treatment services with an HIV component.

While targeted capacity development represents an outstanding approach to more localized problems, the Nation as a whole still has a huge gap between public sector treatment needs and their availability. In response, the appropriation increase of $275 million provided in 1999 for the SAPT Block Grant effectively and substantially increased alcohol and drug abuse prevention and treatment service availability nationwide. In FY 2000, an increase of $30 million will help sustain this growth in service capacity. The budget also proposes that $100 million, or 6.2 percent more be dedicated to closing the gap in services through advance approval of an FY 2001 increase.

Another aspect of addressing substance abuse service needs is filling gaps in prevention programming identified by the States. Despite initiatives undertaken by the justice, educational, law enforcement, and health sectors these gaps continue to exist. By FY 2000, CSAP will have awarded State Incentive Grants to 21 Governors= offices to coordinate prevention efforts, identify major gaps, and initiate Abest practice@ programs where needed. Often, this is in underserved and minority populations. The FY 2000 request will permit awards to four new States to prevent substance abuse practices before they occur, particularly among youth.

Increasing Knowledge in Critical Service Areas

SAMHSA=s mental health and substance abuse service programs play a dual role in system improvement - they not only fill existing gaps in service need, they do so utilizing practices scientifically proven to be effective. Optimal outcomes and high service efficiency are thus achieved. Understanding how to do so

is accomplished through Knowledge Development and Application (KDA) programming directed to the most critical gaps in current knowledge, and the highest priorities for service system improvement. The FY 2000 request maintains support for mental health and substance abuse treatment KDAs at 1999 levels, but proposes a $26 million reduction for substance abuse prevention.

Several of the most important areas to be addressed through the KDA program in FY 2000 include:

- National Agenda Against Underage Drinking - This cross-cutting initiative will address the growing problem of underage alcohol consumption through a comprehensive set of efforts to prevent, postpone, and reduce underage drinking. The components include replication of proven effective prevention models, development of new prevention models for the 18 to 21 age group with a focus on binge drinking on campus, assessing mental health and alcohol problems within the context of a prevention program and intervening/referring for treatment, and assisting States in reducing underage drinking through the development and initiation of multi-State strategies.

- Bioterrorism - A new initiative will help prepare for the behavioral and psychosocial consequences of terrorist threats and events. A scientifically-driven response plan does not currently exist, yet the psychological impact has been substantial in actual instances of bioterrorism.

- Women and Violence - The majority of women who have been treated for addiction and mental disorders have experienced physical and/or sexual abuse at some point in their lives. This cross-cutting initiative provides an additional opportunity for SAMHSA=s Centers to work collaboratively to promote and improve the integrated service delivery system for women and their children affected by violence. The initiative has three major components: (1) to provide cross training for service providers from diverse backgrounds; (2) to communicate information regarding new service approaches and improved service delivery systems; and, (3) to expand current assessment and evaluation programs to assess the effectiveness of substance abuse/mental health treatment programs in addressing health consequences of domestic and sexual violence.

- Strengthening Families - This study will identify the best parenting and family programs for preventing substance abuse, and reducing associated behavior such as child abuse and violent behavior. Results will be demonstrated in community agencies and communicated to practitioners nationwide.

- Community Action Grants - Community action projects are small-scale, time-limited awards to communities which agree to adopt exemplary mental health practices. Each such practice model must meet objective, evidence-based criteria of success. Such projects have been established around the country, including 11 in Hispanic communities, and an additional 20 awards are planned for 1999 and 30 awards are planned 2000.

These projects indicate both the diversity and the creativity evident in SAMHSA=s KDA portfolio. Numerous other projects and activities supported with KDA resources include operation of consumer

clearinghouses and websites; development and communication of best practice information; cooperative arrangements with other federal agencies, such as Justice, Veterans Affairs, the National Institutes of Health, and others on mental health and substance abuse issues of mutual concern; and considerable efforts to understand service needs in rural and Native American communities. The KDA program is highly successful in meeting the many demands for a quick and effective federal response to mental illness and substance abuse problems.

Improving Program Management

The FY 2000 budget includes an increase of $4.5 million for management and oversight of SAMHSA program activities. These resources will cover costs of the January 1999 and January 2000 pay raises; increased rental costs; and the annualized salary costs of critical new and replacement hires made in 1999. Staffing levels for SAMHSA as a whole are expected to decline in 2000 from 574 to 565. The total amounts requested for this account include the effect of a six percent annual limit on the rate of increase for the costs of physicians= compensation.

With respect to SAMHSA=s automated information infrastructure, all computer systems have been reviewed and, if necessary, adjusted to be Year 2000 compliant. To date independent verifications and validations have been conducted for four of the five mission critical systems, and all have been certified as compliant.

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SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Program Mechanism Summary Table

(Dollars in Thousands)

	FY 1998 Actual		FY 1999 Enacted		FY 2000 Request	
High Risk Youth:	**No.**	**Amt.**	**No.**	**Amt.**	**No.**	**Amt.**
Cooperative Agreements:						
Continuations	---	---	13	5,980	15	7,0
Competing:						
New	13	5,954	3	1,020	---	
Renewal	---	---	---	---	---	
Subtotal, Cooperative Agreement	13	5,954	16	7,000	15	7,0
Contracts	---	46	---	---	---	
Total, High Risk Youth	**13**	**6,000**	**16**	**7,000**	**15**	**7,0**
Total National Data Collection	1	**18,000**	---	---	---	
Total, Protection and Advocacy	**56**	**21,957**	**56**	**22,957**	**56**	**22,9**
Set-Aside	---	(439)	---	(459)	---	(4
Total, PATH	**56**	**23,000**	**56**	**26,000**	**56**	**31,0**
Set-Aside	---	(690)	---	(779)	---	(9
Mental Health Block Grant	**59**	**275,420**	**59**	**288,816**	**59**	**358,8**
Set-Aside (Non-Add)	---	(13,771)	---	(14,441)	---	(17,9
Substance Abuse Block Grant	**60**	**1,310,107**	**60**	**1,585,000**	**60**	**1,615,0**
Set-Aside (Non-Add)	---	(65,505)	---	(79,250)		(80,7

B. CENTER FOR MENTAL HEALTH SERVICES

Overview

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA	$451,268,000	$513,737,000	$588,737,000	$75,000,000

Each year, as many as 44 million American adults experience some form of mental disorder. Of these adults, an estimated 10 million experience a serious mental illness of such intensity and duration that employment, physical health, housing, and the overall quality of life for them and their families are dramatically affected. Estimates for the Nation=s children are equally significant. Approximately 13.7 million children and adolescents between the ages of 9-17 experiencing a diagnosable mental disorder in any one year. Of these children, 3.5 to 4 million have a serious emotional disturbance of such severity that it affects the child=s ability to function at home, to learn at school, and to engage in neighborhood or community activities.[3]

Despite the millions of American adults, adolescents, and children who experience mental disorders and serious emotional disturbances, fewer than one in four receives appropriate treatment for his or her disorder. Of those who do not receive care, many appear in other service systems that are not able to respond fully to their needs, among them welfare, education, or justice.

From Institutions to Community Systems of Care

CMHS programs are the legacy of decades of work to create community-based systems of care to people with serious mental and emotional disorders to live productive and fulfilling lives within their communities. The availability of empirically-validated models of community interventions has been linked to the important and historic trend of reduced institutional care and increased community mental health services. In 1981, almost two thirds of dollars spent by State mental health agencies went to inpatient hospitals. In 1993, dollars spent nationwide for community-based services exceeded those spent for inpatient services for the first time. State and county mental hospital bed utilization has decreased from 413,066 beds in 1970, to 93,058 beds in 1992. It is expected that the decline in expensive institutional bed utilization will continue

[3] It is estimated that a significant number of children below the age of 9 suffer from serious emotional disturbance; unfortunately, insufficient research has been conducted to determine with precision the prevalence rates in these very young children.

as increasingly effective community-based services become available. However, major challenges remain in creating community systems of care that respond to the needs of persons with mental health problems through integrated services that enhance self-sufficiency and maintain normal connections to home, school and work, while preserving the respect and dignity owed to all citizens.

People with the most serious mental disorders--psychoses such as schizophrenia and affective disorders such as bipolar illness and severe depression--frequently exhaust their health insurance benefits, leading to reliance on the public mental health care system and frequently to Medicaid and Medicare. In addition, individuals with serious mental illnesses often require services and support not only from the mental health sector, but also from a variety of public and private agencies to help with housing, primary health care, rehabilitation, employment, substance abuse, and other supportive service needs. Yet, all too often, the system of services they must negotiate is fragmented, confusing, and rapidly changing. Indeed, consumers and providers of mental health services face a host of additional uncertainties in the wake of State-level health care reform initiatives, the growth of managed care, national welfare reform, and Social Security disability reform. What has been called for has been a central resource to help address these nationwide issues.

The Role of the Center for Mental Health Services

In its unique dual role, CMHS supports both knowledge development about and the delivery of comprehensive mental health services, both designed to bridge the gap between access to care and the mental health needs of Americans. Through its national programs, CMHS develops new strategies and highlights effective practices, both of which are grounded in the latest research-based treatments and support services. By promoting integrated community-based services, CMHS has opened the door to a comprehensive service system--often termed a system of care--for those in need of continuing mental health intervention. Through its formula and discretionary programs, including the Block Grants for Community Mental Health Services, Projects for Assistance in Transition for Homelessness (PATH), Knowledge Development and Application, and Comprehensive Mental Health Services for Children and their Families, CMHS provides integrated services to the most vulnerable populations, from children and adolescents with serious emotional disturbance to adults with serious mental illness, from those with mental illness involved in the criminal justice system to those homeless on our nation=s streets.

Initiatives supported in FY 1999 and 2000 will continue to focus on the SAMHSA GPRA program goals using the five organizing principles that underlie CMHS=s mission:

Improving Today=s Mental Health System for Tomorrow- Through its Knowledge Development and Application (KDA) program that focuses on the delineation of exemplary practices to meet difficult mental health service needs, CMHS works with States and communities to develop, implement, and evaluate state-of-the-art service approaches to meet the most challenging mental health service issues for children, adolescents, and adults. CMHS has continued its work to ensure application of exemplary practices at the local level through both its Community Action Grant program and support for special projects that

synthesize our latest understanding of mental illness treatment approaches and their application in the field. In addition, the Comprehensive Mental Health Services for Children and Their Families program continues to foster the development of innovative community-based, family-centered systems of care to address the comprehensive needs of children with serious emotional disturbances and their families.

Linking Mental Health with Other Service Systems - CMHS has forged numerous strategic partnerships with other national, state, and local organizations to respond to issues that transcend the role of mental health services alone. For example, in collaboration with SAMHSA=s Center for Substance Abuse Treatment and the Department of Justice=s National Institute of Corrections, CMHS supports the national GAINS Center, a program that trains teams of mental health, substance abuse, and corrections personnel to deliver integrated services within the criminal justice system to individuals with co-occurring mental health and substance use disorders. In two important areas that focus on building resilience and promoting mental health in extraordinary circumstances, CMHS staff work closely with the Federal Emergency Management Agency (FEMA) to provide crisis counseling services to people who have experienced the trauma of natural and terrorist disasters. Similarly, CMHS staff work in partnership with the DHHS Office of Refugee Resettlement to address the mental health needs of refugees. These important interagency partnerships are just a few of the many linkages that bring mental health service focus to key human services programs. Other agreements have been developed in such areas as work with the homeless population, individuals with or at risk of HIV/AIDS, children=s mental health, employment interventions, managed care, and mental health professional workforce training.

Engaging Consumers as Partners in Change - CMHS serves increasingly as the Federal voice for the rights of mental health consumers across the nation, a role that has become increasingly important in the wake of the health care revolution sweeping the country. CMHS continues to work to protect the rights of consumers in institutions through the Protection and Advocacy for Individuals with Mental Illness program, and serves in a federal leadership role not only in promoting consumer and family participation in the planning and delivery of services, but also in educating the public, policy makers, and the media about the damaging effects of the continuing stigma associated with mental illness.

Addressing Emerging Mental Health Needs - Just as the health care system is changing, the mental health needs of our nation, too, are in continual flux. Thus, throughout its work, CMHS has infused an awareness of the disparate ways in which mental health services must be provided, based on cultural and ethnic issues, gender, age, disability, and geography. CMHS staff continuously assess and evaluate the mental health service system and work with health care providers and consumers to identify emerging mental health issues arising from the increasingly diverse community we serve. The aim is to work actively to develop initiatives to meet these emerging needs.

Implementation of Agency Program Goals

CMHS programs support three of the four SAMHSA/GPRA goals. CMHS=s Knowledge Development and Application Programs support both, Goal 1: Bridging the gap between knowledge and practice, and

Goal 2: Promoting the adoption of best practices. Goal 1: Bridging the gap between knowledge and practice will be measured in the GPRA Performance Plan by the success of the following KDA programs: the Access to Community Care and Effective Services (ACCESS), and the Employment Intervention Demonstration Project (EIDP). Goal 2: Promoting the adoption of best practices will be measured by the success of the Knowledge Exchange Network (KEN), and the Community Action Grant (CAG). Finally, CMHS=s programs including Block Grants for Community Mental Health Services, Projects for Assistance in Transition for Homelessness (PATH), and Comprehensive Mental Health Services for Children and their Families, support SAMHSA/GPRA Goal 3: Assuring Services Availability/Meeting Targeted Needs. See the budget narrative under each respective program for further description. See also the GPRA Performance Plan for specific performance measurement information.

FY 2000 Agenda

For Fiscal Year 2000, CMHS has designed a portfolio that builds on the strengths of current program knowledge and addresses emerging needs in communities throughout the country. The CMHS portfolio is described in detail in the sections that follow. Moving into the 21st century, CMHS will facilitate access to a mental health care service system that is proactive, responsive, accountable, and integrated whether needed by a child, adolescent, adult or elder. The product will be an America in which even those who are most vulnerable and most in need are full and active participants in the fabric of their communities. The vision of a mentally healthy America is the guiding principle that drives the FY 2000 agenda of the Center for Mental Health Services.

CMHS proposes significant increases in Federal support for community mental health services through the Mental Health Block Grant (+24%) and the PATH program (+19%). These programs help States ensure that state-of-the-art treatments and innovative community-based programs are available to public sector mental health clients. The proposed increases in Federal support will enable the States to serve a larger proportion of the nation=s most vulnerable populations, including homeless people, children, minorities, and women.

Though no increase is requested in FY 2000 for the continuing KDA funded programs, CMHS will initiate several new projects to help States and communities address some the most challenging issues facing the field. New projects will focus on the mental health repercussions of bioterrorism, employment concerns for persons with disabilities, and a continuum of care for individuals living with HIV/AIDS. Additionally, CMHS will expand the Community Action Grant program and develop peer to peer technical assistance networks.

CMHS is also continuing a major KDA program initiated in FY 1999 that supports the delivery and improvement of mental health services in our nation=s schools. This ambitious program is designed as a comprehensive, interagency collaborative approach linking local and State mental health service providers with schools. School districts will implement a wide range of early childhood development, early

intervention and prevention, and mental health treatment services that appear to have the greatest likelihood of preventing violence among children.

Because the requested budget increases are for ongoing CMHS programs, performance information is located primarily in the GPRA Performance Plan.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
Center for Mental Health Services
Mechanism Table
(dollars in thousands)

	FY 1998 Actual		FY 1999 Enacted		FY 2000 Request	
Knowledge Development and Application:	**No.**	**Amt.**	**No.**	**Amt.**	**No.**	**Amt.**
Grants:						
Continuations	17	$1,998	76	$8,064	161	$40,848
Competing:						
New	100	10,657	114	36,410	86	6,440
Renewal	---	---	---	---	---	---
Supplements:						
Administrative	---	352	---	---	---	---
Subtotal, Grants	117	13,007	190	44,474	247	47,288
Cooperative Agreements:						
Continuations	48	15,280	79	27,984	68	22,539
Competing:	---	---	---	---	---	---
New	45	15,511	9	2,800	4	1,647
Supplements:						
Administrative	(34)	1,740	---	1,050	---	---
Subtotal, Coop. Agreements	93	32,531	88	31,834	72	24,186
Contracts	30	12,426	36	21,656	44	26,490
Total, Knowledge Develop & Appl	**240**	**57,964**	**314**	**97,964**	**363**	**97,964**
Children's Mental Health Services:						
Grants:						
Continuations	27	41,660	25	33,514	51	63,695
Competing:						
New	14	12,571	28	28,000	---	---
Supplements:						
Administrative	---	3,142	---	---	---	---
Subtotal, Grants	41	57,373	53	61,514	51	63,695
Cooperative Agreements:						
Continuations	---	---	---	---	1	1,000
Competing:						
New	---	---	1	1,000	---	---
Supplements:						
Administrative	(1)	595	---	---	---	---
Subtotal, Coop. Agreements	---	595	1	1,000	1	1,000
Contracts	15	14,959	18	15,486	18	13,305
Total, Children's Mental Health Services	**56**	**72,927**	**72**	**78,000**	**70**	**78,000**
Protection & Advocacy:						
Total, Protection and Advocacy	**56**	**21,957**	**56**	**22,957**	**56**	**22,957**
Set-Aside (Non-Add)	---	(439)	---	(459)	---	(459)
PATH:						
Total, PATH	**56**	**23,000**	**56**	**26,000**	**56**	**31,000**
Set-Aside (Non-Add)	---	(690)	---	(779)	---	(929)
Mental Health Block Grant:						
Block Grant	**59**	**275,420**	**59**	**288,816**	**59**	**358,816**
Set-Aside (Non-Add)	---	(13,771)	---	(14,441)	---	(17,941)

B. CENTER FOR MENTAL HEALTH SERVICES
1. Knowledge Development and Application (KDA) Program

Authorizing Legislation - Section 501 of the Public Health Service Act.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA	$57,964,000	$97,964,000	$97,964,000	---

2000 Authorization

PHSA Section 501 ..... Indefinite

Purpose and Method of Operation

The CMHS Knowledge Development and Application (KDA) program makes a difference to people by promoting the continuous improvement of service delivery systems for children and adults with serious mental health problems. KDA projects improve service systems by providing effective cross-system service models and by reducing service delivery system fragmentation. The KDA program includes multi-site studies and other knowledge development activities that identify the most effective service delivery practices, knowledge synthesis activities that translate program findings into useful products for the field, and knowledge application projects that support adoption of exemplary service approaches throughout the country. Results from the KDA programs are widely disseminated throughout CMHS=s programs including the Comprehensive Mental Health Services for Children with Serious Emotional Disturbance and their Families Program, the Projects for Assistance in Transition from Homelessness (PATH) program, and the Mental Health Block Grant program. This dissemination creates a comprehensive approach that supports adoption of evidenced-based treatment practices in mental health. In FY 1999, the Violence in Schools Initiative: Expanding Resiliency was added to this comprehensive approach to support improved services and outcomes for the millions of persons suffering from serious mental problems.

Violence in Schools Initiative: Expanding Resilience

On October 21, 1998 the President signed the Omnibus Appropriation Act (P.L. 105-277) which provides a minimum of $100 million for the Violence in Schools Initiative to be carried out in collaboration with the Department of Education and the Department of Justice. The CMHS project within this initiative will be known as AExpanding Resiliency@. This project will support delivery and improvement of mental health services in schools for children who are at risk of violent behavior. The Act provides CMHS with $40 million which represents 41% of the KDA budget in FY 1999 and FY 2000.

CMHS=s ambitious program is designed to make the most effective use of these resources, using proven interventions and a comprehensive and collaborative interagency approach linked to local and State mental health entities. School districts will implement a wide range of early childhood development, early intervention and prevention, suicide prevention, and mental health treatment services that appear to have the greatest likelihood of preventing violence among children.

The program=s goal is to increase the percentage of knowledge application activities that change user practices or are adopted by others. Through this initiative CMHS hopes to decrease the rate of violence in schools and increase the percentage of proposed mental health activities actually implemented in schools. CMHS will collect data on the number or percentage of students engaged in violent behavior, incidents of serious and violent crime in schools, suicide attempts, and students suspended and/or expelled from school.

This Initiative includes the following five components:

The Safe Schools, Healthy Students Program is an interagency grant program linking CMHS, the Department of Education and the Department of Justice, which will help school districts develop and implement a community-based comprehensive strategic plan which must be linked to the local and/or State mental health entity. This program will target interventions that have been empirically tested and demonstrated successfully in the fields of child development and education. The initiative provides funding for six different elements of activities including: mental health treatment services, early childhood development services, prevention and early intervention, school security, safe school policies, and educational reform,. SAMHSA has responsibility for both mental health treatment services and early childhood development services, as follows.

- Mental Health Treatment Services: Each school district must describe in detail a plan for identifying and serving children with mental health needs. Interventions link directly to the troubled and vulnerable children who are at risk for emotional/behavioral problems. There will be at least three categories of activity: 1) screening and assessment in school settings, 2) provision of effective school-based mental health services, and 3) provision for referral and follow-up of children with more severe problems and their families by the local public mental health services organization. Examples of such activities would incorporate a wraparound approach to service delivery inclusive of individual and family counseling, multi-systemic theory, and functional family therapy.

- Early Childhood Development Services: Each school district must describe how their plan to support early childhood development services will promote safe and healthy environments for children to live and learn. While serious violence is typically not exhibited until later in life, schools are increasingly recognized as a key component in the healthy growth and development of individual children, creating a potent environment early in life. The quality of child care, early education, and family support programs are viewed as affecting the probability of late aggression and violence. Early childhood development services include effective parenting programs and home visitation to

teach parents and other caregivers, make quality early assessments and provide ongoing monitoring of progress, focusing on the strengths of families.

School Action and Piloting Grants - Modeled after our highly successful Community Action Grants, this component includes research coordination with NIMH. This program offers many community groups, including families, providers, social agencies, non-profit organizations and faith communities the opportunity to Amanualize@ their existing violence prevention programs targeting children with emotional and behavioral difficulties and prepare programs for evaluation by a panel of experts for further refinement and dissemination. Schools and communities are given the opportunity to highlight current innovative programs and subject them to the usefulness of evaluation and consultation on dissemination strategies.

Technical Assistance Center - CMHS will link with local communities and schools to net to engage them in support of mental health interventions on behalf of all children with their public mental health programs.

Public Education/Awareness Campaign - A public awareness campaign will target organizations, rather than individuals as is typical in most similar events, that have or should have an interest in the well being of children such as foundations, PTAs, schools, and universities.

Innovations- This effort will provide an opportunity, using interactive technological advances, for the development of creative alternatives to reduce violence and develop training options to address aggressive behaviors to be used by students and their families, as well as educators and other concerned community leaders. Much of these technologies have baseline research supportive of their utility and seem very promising, especially for the sometimes difficult to engage adolescent student.

Knowledge Development Accomplishments:

Homeless Persons with Mental Illness: The Access to Community Care and Effective Services and Supports (ACCESS) Program, initiated in FY 1993, was designed to evaluate the effectiveness of integrated service approaches for this vulnerable population. It is the last year of program implementation and data collection. Among the most important observations are:

C *Homeless persons can be engaged.* The last year of data collection continues to demonstrate that it is possible to engage some of the hardest-to-reach homeless people, that is, persons with severe mental illnesses, into services after a relatively brief period of time--52 days on average even for those most difficult to approach.

C *Improvements in client outcomes from comprehensive services are dramatic.* The newest wave of data collection continues to show significant improvement in service outcomes. Within the first 3 months after being engaged in services, these individuals reported a 45% reduction in the number of days homeless; and after 12 months, the number of days homeless had reduced by 74%.

- *Integration efforts yield improved service linkages*. Findings, published in the *American Journal of Public Health* in October 1998, show that more integrated service delivery system result in better housing outcomes for homeless persons. There are still policy and environmental variables that affect systems integration that require further evaluation. For instance, even when sites employ similar strategies and are equally successful in putting them in place, they may still differ in the level of integration achieved.

The ACCESS program contributes to the achievement of Goal 1-- Bridging the Gap between Knowledge and Practice. See GPRA plan for standard measures and program specific measures, and update data.

Employment of Persons with Serious Mental Illness: The Employment Intervention Demonstration Program (EIDP), initiated in FY 1995, was designed to identify model interventions that achieve the best employment results for people with severe mental illness. While far from complete, the study is already yielding important information. Among the most important preliminary observations are:

- *People with Serious Mental Illness are Employable*. Over half (52%) of those receiving services for 9 months or more had at least one employment experience, working an average of 20 hours per week an earning an average of $5.85 an hour. Those who worked held more than one job, with an average of 1.9 jobs per person employed.

- *People with Serious Mental Illness are Productive.* The work motivation among more than 1,600 clients in the study is very high and has remained very high during the course of the study. The productivity potential of EIDP participants is evident in the fact that they held a total of 1449 jobs earning $1.8 million dollars in the first eight quarters of the EIDP. They logged 346,405 hours on-the-job and 18% worked full-time.

- *Integrated Team Approach Locates Jobs*. Preliminary results from some sites show the advantages of providing integrated team services to locate jobs for persons with severe mental illness over traditional, non-integrated approaches.

The EIDP contributes to the achievement of Goal 1-- Bridging the Gap between Knowledge and Practice. See GPRA plan for standard measures and program specific measures.

Homeless Prevention : The CMHS/CSAT Collaborative Program to Prevent Homelessness is in its final of three years of program activity. Preliminary observations demonstrate that there are effective ways to engage clients with serious mental illnesses and/or substance use disorders in prevention services and treatment. Heretofore, many authorities discounted the advantages of preventive services for persons at risk for homelessness. The experimental programs appear to have very positive retention rates, which anticipate stronger prevention outcomes. Also, the program has been able to design a multi-site study that

successfully incorporates eight diverse communities, service populations, and intervention strategies, and thus will generate results more reflective of the larger national community and which will allow easier replication in more diverse communities throughout the Nation.

Effects of Managed Care on Adults with Serious Mental Illness: CMHS has collaborated with its SAMHSA partners to fund a set of multi-site studies looking at the impact of managed care on several vulnerable populations -- SMI adults, mothers and their children, and substance abusers. The goal of this program is to develop descriptive information on substance abuse and mental health services available to clients in the managed care environment and to evaluate the impact of managed care systems on the use, cost and outcomes of services for these populations.

In its final year of funding, this ground-breaking program has developed considerable technology for looking at consumers of mental health and substance abuse services within a managed care environment. These advances include:

- New protocols for interviewing consumers with SMI regarding service quality and outcomes.
- A taxonomy for classifying types of managed care programs.
- Population-based sampling methodology for recruiting persons with SMI who are not engaged in the service system.

Furthermore, this project includes both the prospective study of 1300 managed care (MC) and fee-for-service (FFS) Medicaid enrollees, as well as an administrative Medicaid database study, which will be the largest of its kind to look at administrative data for this target population. CMHS expects that this program will greatly expand the knowledge base on service quality and outcomes in managed care settings. Data from this study will have tremendous policy implications for the fields of mental health services and managed care. Preliminary findings include:

- MC programs appear to enroll higher functioning consumers, as indicated by marital and parenting status. Two-thirds of enrollees in managed care indicated that they are living with children, whereas only half of those in FFS indicated the same.
- Consumers in MC programs were less likely to receive long-term inpatient care (1.4% vs 5.3% FFS).
- Consumers in FFS programs were five times more likely to be receiving newer medications, such as clozapine.
- Consumers in MC programs were more likely to get primary health care (61% vs 50% FFS).

- FFS programs cost consumers more of their own money. One-fourth of consumers in FFS had out of pocket costs for health and behavioral health services, whereas fewer than one-sixth of managed care enrollees had out of pocket costs. Similarly, more FFS enrollees reported receiving mental health services which were not covered by their insurers.

Effects of Managed Care on Children with Serious Mental Illness: Preliminary findings from the Managed Care Impacts on Children Study conducted at the University of Pittsburgh show the following trends:

- Managed Care Organization (MCO) participants are 1/3 as likely to use specialty MH services as compared with Fee-for-Service (FFS).

- African-American youth in MCO are half as likely to use MH specialty care as are European-American youth in FFS.

- Children with psychiatric hospitalizations are less likely to join an MCO and tend to disenroll at a higher rate.

- MCO participants are more likely to experience delays in care.

- Families liked joining the MCO for the non-mental health benefits: eye, no co-pay pharmacy and dental benefits.

- Parents would join the MCO for non-mental health benefits, yet enroll their kids in FFS to get the more flexible MH benefits for their children.

HIV/AIDS Demonstration: This program was a collaborative effort of SAMHSA, CMHS, HRSA, and NIH. It was the first Federal effort to develop models of delivery of mental health services to people living with and/or affected by HIV/AIDS. This program has shed new light on how to develop services and develop systems of care. Findings from the program indicated that early intervention with mental health services can improve adherence to medical and other treatments. Mental health treatment services and HIV education play an important role in preventing children and adolescents whose parents have HIV or AIDS from acquiring the virus themselves. These and other important findings are currently being disseminated to the field.

Other Ongoing Knowledge Development and Application Activities

During the past three years, CMHS has developed a strong, responsive knowledge development study portfolio that addresses the areas of greatest opportunity for service improvements. CMHS recognizes that this knowledge needs to be combined with learning from other sources--including the National Institute of

Mental Health--to maximize its utility. These programs will supply more lessons, more best practices and more opportunities for CMHS to work with the field to achieve improved services and better outcomes for children and adults.

- *Consumer and Family Network Grants* provide consumers and their families with support and assistance in contributing to the development of effective treatment programs for persons with mental illness.

- *Consumer and Family Technical Assistance Centers* provide technical assistance to consumers, families and supporters of persons with mental illness with two important supports: (1) explicit training and assistance designed to enhance the skills persons need to be effective participants in policy development, decision-making and strategic planning, including development of leadership skills; and (2) technical support for the creation and maintenance of a communication network among consumers, families and supporters which facilitates the flow of information and provides opportunities for sharing lessons learned and good advice among peers.

- The *Effectiveness of Consumer-Operated Human Services* program examines consumer-operated, self-help programs providing human services to explore the extent to which these service programs are effective. This multi-site study is: 1) determining what effect participation in consumer-run services has on selected client outcomes; 2) examining program costs; 3) examining whether these programs promote greater levels of personal responsibility and independence; and 4) examining the differences in the training, organization, infrastructure and resource needs of consumer-operated self-help programs from similar community-based, professionally-operated services.

- The *Circles of Care: Designing and Assessing Service System Models for Native American Indian and Alaska Native Children and Their Families* project is providing a unique opportunity to enfranchise Native American communities in the national drive toward establishing effective systems of care for children with serious emotional disturbances. It also has established Alaboratories@ to enable culturally distinctive communities to establish their own outcome expectations for the treatment of their children, a cornerstone of the commitment of both CMHS and the Administration to culturally competent, relevant mental health and substance abuse treatment programs in the United States.

- The *SAMHSA-wide Starting Early/Starting Smart* program was initiated in FY 1997 to identify interventions that have the best chance of preventing serious emotional disturbances and substance abuse in children ages birth to seven. The study is designed to develop and test a comprehensive approach for working with families with young children who are at risk for mental health and substance abuse problems due to family history and environment.

- The study on *Mental Health Services for Aging Persons in Primary Care Settings* is developing and measuring the effectiveness of models for improving the connection between mental health and primary health care. This initiative includes the active collaboration of the Health Resource Services Administration=s Bureau of Primary Health Care and the Department of Veterans Affairs. The need to better integrate mental health screening, assessment, and basic clinical interventions with primary health care delivery is one of the most pressing service system issue for elderly Americans with mental health problems.

- The *HIV/AIDS Treatment Adherence/Health Outcome and Cost Study* reflects the collaboration of six Federal entities**C**the Center for Mental Health Services, which has lead administrative responsibility, and the Center for Substance Abuse Treatment, both of which are components of the Substance Abuse and Mental Health Services Administration (SAMHSA); the HIV/AIDS Bureau in the Health Resources and Services Administration (HRSA); and the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, all of the National Institutes of Health (NIH). The HIV/AIDS Cost Study is the first-ever Federal initiative designed to study integrated mental health, substance use, and primary medical HIV treatment interventions. More importantly, the study is the first Federal effort to determine if an integrated approach to care improves treatment adherence, produces better health outcomes, and reduces the overall costs associated with HIV treatment.

- The *HIV/AIDS High-Risk Behavior Prevention/Intervention Model for Young Adults/Adolescents and Women Program* is a collaborative venture aimed at bringing AIDS prevention into the community. Project SHIELD also represents an opportunity to move the field of HIV prevention research forward along the two parallel continuum of innovative intervention design and rigorous evaluation. The multisite nature of this HIV prevention trial has the potential to test the efficacy of two brief interventions and generalize the study results to more than one study population. In essence, the question posed by Project SHIELD is: can the principles underlying demonstrably effective HIV prevention interventions be applied in brief formats to real world client sand still be effective in reducing HIV risk behaviors? Although the HIV prevention field has traditionally relied on self reports of risk behaviors as the primary outcome Project SHIELD will not only measure participants= self reported behavior change, which may be biased, but will *actually* measure reductions in diseases; diseases such as common STDs that are associated with considerable adverse sequelae and may facilitate HIV transmission.

- The *Supported Housing Study* was designed to enhance knowledge about how different housing approaches contribute to the rehabilitation and recovery of individuals with serious mental illness, using individual study sites and a coordinating center. In particular, it evaluates the effectiveness of the supported housing model. A two-phase study, the sites will each implement supported housing as well as one other housing intervention. The initial phase involves a process evaluation of the implementation, the latter phase will include both within-site and cross-site outcome evaluations.

- The *Jail Diversion Study* addresses a services priority: diversion of individuals with severe mental illness and substance abuse disorders from the criminal justice system to community treatment alternatives. Together with CSAT, CMHS seeks to provide an empirical basis for understanding the effectiveness of pre-booking and post-booking models of criminal justice diversion in improving selected outcomes for individuals with co-occurring disorders who are alleged to have been involved in criminal activity. The primary outcomes to be assessed include but are not limited to: criminal recidivism, time incarcerated, psychiatric hospitalization, psychiatric status, functional status, continuity of participation in treatment, homelessness, emergency treatment utilization, and reduction of frequency of substance abuse.

- The *Women and Trauma Study* will look at women with histories of violence and co-occurring mental health and substance abuse disorders. Women with this cluster of concerns seem to have greater utilization of services and longer inpatient stays. Children of this target population are also at greater risk for developing emotional problems. Yet, the treatment systems that deal with these different types of problems are typically organized separately and independently.

  The literature clearly shows that the violence-related problems of women with co-occurring disorders and the consequences on their children have not been adequately addressed. This study, with 11 sites plus a Coordinating Center, will examine strategies for the integration of treatment interventions for this target population of women and their children. It will also consider the integration of different systems that have historically offered compartmentalized treatment to women for one or more of these problems. This study will develop new knowledge about the feasibility and efficacy of treating these mental health, substance abuse, and trauma disorders simultaneously in an integrated intervention, keeping in mind the needs of both the women consumers and their children.

- The *Homeless Families with Children Program* examines strategies to provide treatment, housing, support, and family preservation services to adults with psychiatric and/or substance use disorders and their children. The program investigates the extent to which these interventions are effective and will be conducted in three phases: clarification and strengthening the intervention, an outcome evaluation of the effectiveness of the intervention, and a dissemination phase. Because families are the fastest growing segment of the homeless population, identifying and disseminating effective interventions for adults and children who are homeless or at-risk for homelessness has become critical.

- The *Child Treatment Effectiveness* initiative, a collaboration between CMHS and NIMH, is developing a standardized treatment package for specific childhood disorders that can be field tested in community settings. This multi-phased project began in FY 1998; field trials are slated

to begin at the end of FY 1999. If found to be effective, these models will be disseminated for adoption in the last phase of the program.

C CMHS is initiating a new *Youth Transition Study* The transition period for youth and young adults with emotional/behavioral disturbances presents unique barriers that put these individuals at significantly greater risk for school failure, involvement with the criminal justice system and/or dependency on social services. These youth have the highest rates of dropout from secondary school and experience the poorest outcomes in later employment, arrests, incarceration, and independent living. The transition period for youth and young adults with emotional/behavioral disorders is further complicated by the lack of coordinated services among the children=s mental health, child welfare, education, adult mental health, substance abuse treatment, and rehabilitation sectors. The resulting poor outcomes for this population also present extreme costs in at least three major areas: a) individuals and families; b) the security of the community; and, c) local, state, and federal government.

The knowledge development activity proposed here will begin to test the effectiveness of identified innovative strategies which indicate promise in successfully linking child and adult systems of care to provide positive outcomes for this population.

Knowledge Application Accomplishments

In FY 1999, CMHS is developing improved methods to synthesize and disseminate to the field comprehensive summaries of best practices in selected topic areas that can simplify the translation of knowledge gained into program practice by practitioners working at the local level. Examples of current knowledge synthesis accomplishments follow.

Co-Occurring Disorders Service Improvement Framework: Recognizing the growing evidence that service coordination is a key element of effective service delivery for persons with co-occurring mental health and substance abuse services, SAMHSA supported a National Dialogue on Co-Occurring Mental Health and Substance Abuse disorders in June, 1998. The dialogue was sponsored by NASMHPD and NASADAD and involved six State Commissioners/Directors of Mental Health and six State Substance Abuse Directors. The dialogue produced a conceptual framework that represents a new paradigm for considering both the needs of individuals with co-occurring disorders and the service system requirements designed to address these needs. It provides for defining co-occurring disorders in severity terms rather than specific diagnoses, thereby encompassing the full range of people who have co-occurring mental health and substance abuse disorders and for focusing on coordination of services for all persons with co-occurring disorders regardless of severity of illness. For those persons with severe disorders, integrated services is necessary. The dialogue has already spurred much policy deliberation in the States and will be continued by the NASADAD and NASMHPD directors at the national level during FY 1999.

National Dialogue on the Implications of the Homeless Study=s Findings for the States: CMHS has again partnered with NASMHPD to synthesize the current findings of the ACCESS Study and related findings elsewhere in the field, to identify those findings with greatest implications for state mental health directors, present the findings to representative directors for policy deliberation and development of action recommendations to all directors in the summer of FY 1999.

Services Information for State Planning and Advisory Council Members: CMHS has commissioned the National Association of Mental Health Planning and Advisory Council members to develop brochures that describe innovative services which should be the subject of State mental health planning activity and to perform a series of follow-up activities designed to give Planning and Advisory Council members ongoing support in using this innovative service information during their deliberations. Consistent with current knowledge development activity, this year=s topics are Assertive Community Treatment and service to the homeless. The Initiative replaces the AInnovation Packets@ initiative from last year as CMHS effort to link KDA with the planning activities mandated under the Block Grant program. It takes advantage of advice and comments from last year=s customers on improving the process.

Assessment of the Evidence Base for the Systems Integration Approach to Serving Persons with Serious Mental Illness: Many of CMHS= studies focus on improving service coordination for persons with serious mental illness who have different problems that affect the quality of their lives negatively. For the first time ever, CMHS brought together teams of researchers, consumers and program providers from all CMHS=s KDA programs to discuss how their individual findings compliment or contradict those of the other programs. While no conclusions were reached, the process was very productive and gives CMHS further directions on next steps to take in formulating an overall strategy for improving service delivery by creating better integration among the multiplicity of agencies serving this needy group of very high-end consumers of public services.

Model Program Standards for the Program for Assertive Community Treatment (PACT): Having supported development of standards and guidelines for evidence-based assertive community treatment (ACT), CMHS has entered a partnership with HCFA to foster use of evidence-based assertive community treatment in States that have not already adopted the practice. Discussions concern distribution by HCFA of descriptions of ACT minimum practice standards, models of appropriate Medicaid funding mechanisms and, possibly, encouragement by the Medicaid Bureau Director that all states encourage and fund the practice.

Survey of Supported Employment Study Findings: The results of a completed CMHS study on Supported Employment were recently published in the Summer 1998 issue of *Psychiatric Rehabilitation Journal*. This study, conducted through Dartmouth University, showed that a supported employment intervention had persistent positive effects on the competitive employment and satisfaction with vocational rehabilitation services of persons with SMI. It is notable that such improvements were attained at no extra cost relative to traditional vocational rehabilitation services. Other issues discussed in the special volume include: job

preferences, ethnocultural factors, co-occurring disorders, and cost-effectiveness implications for managed care.

Adoption of Exemplary Practices

In addition to information synthesis and dissemination, CMHS is expanding efforts to support the adoption of exemplary practices in mental health service delivery in communities throughout the Nation. Examples include:

Community Action Grants

The Community Action Grant Program (CAG) was initiated in FY 1997. The goals of the program are to: 1) identify exemplary practices, build consensus for the adoption of the exemplary practice and then provide technical assistance for eventual adoption and implementation of the exemplary practice into the systems of care; (2) improve technology transfer efforts to increase interaction among users and producers of knowledge and help them use that knowledge to improve mental health systems; and (3) synthesize and disseminate new knowledge about effective approaches to providing comprehensive community-based services to persons with severe mental illnesses. The target population for this program includes two subgroups: adults with severe mental illness and children/adolescents with serious emotional disturbances and their families.

In FY 1998, additional funds from each of the three SAMHSA Centers were offered to encourage the identification and adoption of exemplary practices in Hispanic communities. The goal of this incentive was not only to recognize, but to actively address, the unique mental health and substance abuse prevention/treatment needs of Hispanic Americans. A second round of 31 CAG grants started in September 1998. Eleven of the 31 grants focus on Hispanic communities. CAGs identify exemplary practice models that meet objective, evidenced-based criteria and support consensus building among key stakeholders to adopt the exemplary practice. Information about these approved exemplary practices is then made available to new sponsors of exemplary practices in other communities. Among those practices being implemented by new grantees are: employment models, assertive community treatment, integrated mental health/substance abuse services, a gatekeeper model for elderly, substance abuse programs, family support and education, substance abuse prevention and children=s Awrap around@ services. Additionally, CMHS=s Community Action Grants are dispersed throughout the country. For example,

- *Consumer Leadership Academy*: In Massachusetts and North Carolina, consumer organizations are taking the lead in building consensus for programs providing leadership skills to mental health consumers.

- *Homeless Mobile Outreach*: A collaborative initiative among agencies in Contra Costa County, Napa Valley, and San Jose, California is working to implement an exemplary practice to conduct outreach to homeless persons with severe mental illness and co-occurring substance abuse problems.

- *Jail Diversion*: Projects in South Carolina and Texas will build consensus among the criminal justice, mental health and substance abuse systems to develop diversion programs for individuals with mental illness and substance abuse problems. The Texas program will target the Hispanic community.

The CAG program contributes to the achievement of Goal 2-- Promote the Adoption of Best Practices. See GPRA plan for standard measures and program specific measures. Preliminary data are not yet available for this program.

The Employment for Persons with Disabilities Initiative: CMHS and SSA have entered into a partnership to fund States wishing to pilot mechanisms which eliminate barriers to employment for persons with disabilities, including mental disabilities. In September, 1998, demonstration grants were awarded to 12 States; 9 of the 12 grants were to States conducting special projects involving individuals with a serious mental illness. In addition Center staff met with the Program Coordinating Center to formulate a technical assistance and monitoring approach to the Program that will improve both the project results and dissemination of those results to the field.

Knowledge Exchange Network: CMHS continues to expand the technical capacity of its *Knowledge Exchange Network (KEN)* initiated in FY 1995. KEN operates a clearinghouse designed to assure the widespread dissemination of information to support the work of all CMHS programs as they seek to improve the delivery of mental health services. The KEN clearinghouse and electronic bulletin board system are supported by technical assistance centers with expertise in special population and program issues.

KEN contributes to the achievement of Goal 2-- Promote the Adoption of Best Practices. See GPRA plan for standard measures and program specific measures, and update data.

Minority Fellowship Program: As part of its continuing effort to foster minority leadership in mental health services, CMHS collaborates with CSAT and CSAP to fund the *Minority Fellowship Program (MFP)*, which provides doctoral-level training to increase the pool of professionals qualified to provide leadership, consultation, training and administration to governmental health agencies and public and private organizations concerned with the development and implementation of programs and services for underserved ethnic minority persons with mental and/or substance use disorders.

HIV/AIDS Mental Health Provider Education Program: The *HIV/AIDS* Mental Health Care Provider Education Program completed its final year of funding in FY 1998. Grants have been awarded in the

Mental Health Provider Education in *HIV/AIDS* Program II to evaluate the dissemination of knowledge on (1) the psychological and neuropsychiatric sequelae of HIV/AIDS, and (2) the ethical issues in providing services to people with HIV/AIDS, to both traditional and nontraditional first-line providers of mental health services, and to evaluate the relative effectiveness of different education approaches. Training approaches are incorporating the most current research-based information and allow easy modifications to reflect changes in the medical regimen for treatment of AIDS.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995	$52,216,000	---
1996	38,032,000	---
1997	57,964,000	---
1998	57,964,000	---
1999	97,964,000	---

Rationale for the Budget Request

The FY 2000 Budget Request proposes to maintain in the KDA Program at the FY 1999 appropriation level.

New activity in FY 2000 is designed to improve the application of existing knowledge; i.e. translating science into services. New initiatives will take advantage of an array of cutting-edge strategies for supporting the Nation=s agents of service system improvement, including consumers, families, state and county governments, as well as a wide variety of public agencies. The specific programs will not only provide communities the information they need about exemplary mental health practices but also provide them with the special tools they will need to make change happen. These tools include methods for engaging decision makers, building consensus, overcoming implementation barriers, using strategic planning effectively, team building, and networking. Perhaps most importantly, CMHS seeks to place consumers, families and consumer supporters in a position to act as change agents on their own behalf in their own communities. The following activities are representative of those to be funded under the Initiative.

- Expansion of Community Action Grants for Service System Change: The Community Action Grant program has been effective in building consensus to implement a variety of exemplary intervention practices in a variety of settings. Within this new round of Community Action Grants, CMHS will pilot an enhanced evaluation mechanism for a subset of 10 projects to allow providers of mental health services to use their quality improvement capacity to contribute to measuring consensus building, program fidelity, and planning for outcome measurement. A portion of the expanded effect will be used to support increased quality improvement capacity to achieve these goals.

- Providing Systems Change Support: CMHS will develop a Strategic Change Program (SCP) that fosters partnering among States and community agencies; uses strategic planning to support systems change; and provides assistance to States in tracking other social service policy issues relevant to mental health consumers. The SCP will operate as a training institute and coordinating center for strategic planning and implementation targeted to Communities and States. The SCP will only engage in activities where interagency partnerships are necessary to accomplish specific service

delivery systems changes targeting carefully identified populations of persons with mental illness or children with serious emotional disturbances.

C Establish Peer-to-Peer Technical Assistance Networks: Under this project, CMHS will improve federal technical assistance by establishing peer-to-peer technical assistance networks, linking CMHS=s services research grantees with communities seeking to improve service and other methods of expanding mutual support within the field. This component of the initiative acknowledges that CMHS has neither the resources nor the expertise to provide all the technical assistance the field needs to accomplish implementation of emerging exemplary practices. Instead CMHS will link experts -- by both learning and experience -- with individuals who are need technical assistance. Peer-to-peer networks will be used to match persons in need with those to whom they can best relate (their peers) who have needed information and expertise. In particular, CMHS will seek to take advantage of the huge body of expertise represented by its own grantees and, again, link that expertise with communities that want to improve services.

C Employment for Persons with Disabilities: Inter-Agency Task Force Initiatives: In addition to the Disability Initiative being taken with SSA described above, CMHS will also support activities of the National Task Force on Employment of Adults with Disabilities and its member agencies to ensure that the many activities designed to increase employment opportunities for persons with disabilities include specific attention to those who have mental disabilities. CMHS will leverage resources dedicated to the entire disability community to the specific needs of persons with mental problems, eliminating duplication and redundancy as well as increasing the opportunities to explore how lessons learned about employment for persons with any disability can be applied to those with specific mental disabilities.

C A Continuum of Care Project: A new Continuum of Care program will examine the extent to which mental health services improve the utilization of all health and human services, improve health and social outcomes, and improve the outcomes of the next generation of children by preventing behaviors that increase risk of contracting HIV/AIDS. The program will seek to increase compliance with medical regimens as well as mental health and substance abuse treatment, reduce risky behaviors, improve life outcomes for children affected by HIV/AIDS, and inform the field of effective models of service and models for integration of services and evaluation that can be replicated.

C A Bioterrorism Initiative focuses on preparedness for the psychosocial and emotional ramifications of terrorist threats and events. The expert field that would permit a scientifically driven response plan to the behavioral and psychosocial consequences of Bioterrorism does not currently exist. Despite the critical necessity and reality of instituting plans, the field needs to be developed and driven to explore the knowledge and activities that will serve to guide state and local planning.

- CMHS=s primary role in the National Agenda Against Underage Drinking will be related to the generation of new empirical knowledge about what brief intervention and treatment models and associated services are most effective for brief intervention or treatment of mental health problems and conditions in the cited underage populations.

- Violence Against Women is also a new cross-cutting initiative that seeks to discover what works to improve women=s outcomes in the utilization of substance abuse and mental health treatment services and to promote the improved coordination of services by developing an integrated service delivery system. CMHS will work with CSAP and CSAT to provide training for health care professionals and students in medical school or other health professions educational institutions. Additionally, CMHS will work collaboratively to expand current assessment and evaluation programs to assess the effectiveness of substance abuse/mental health treatment programs in addressing health consequences of domestic and sexual violence.

B. CENTER FOR MENTAL HEALTH SERVICES
2. Children=s Mental Health Services Program

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$72,927,000	$78,000,000	$78,000,000	---
2000 Authorization				
PHSA Section 565 (f)				Indefinite

Purpose and Method of Operation

The Comprehensive Community Mental Health Services for Children and Their Families Program was implemented in FY 1993 to encourage the development of intensive community-based services for children with serious emotional disturbances and their families based on a multi-agency, multi-disciplinary approach involving both the public and private sectors. The target population for these grants is children and adolescents, from birth to 18 years of age (unless specifically extended by States to persons less than 22), with a diagnosable serious emotional, behavioral, or mental disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV and that results in a functional impairment which substantially interferes or limits the child=s role or functioning in family, school, or community activities.

Funds are available to States, political subdivisions of States, territories, and Indian tribes or tribal organizations. Funds are used to build on the existing service infrastructure so that the array of services required to meet the needs of the target population is available and accessible. Grants are limited to a total of 5 years and grantees must develop sources of non-federal matching contributions which must increase over the term of the award from $1 for each $3 of Federal funds in the first year to $2 for each $1 of Federal funds in the final year.

The goals of the Program are to:

- expand the service capacity in communities that have developed an infrastructure for a culturally competent, community-based, coordinated, interagency approach to serving children and adolescents in the target population and their families;

- provide a broad array of mental health services and supports that are community-based, family-centered and tailored to meet the needs of the child or adolescent through an individualized service planning process; and

- ensure an expanded role for families which includes full involvement in the development of local services and supports for their children.

Evaluation: The program, a leader in interagency collaboration, was recently recognized with Vice President Gore=s Hammer Award, highlighting the accomplishments of an interagency team formed by CMHS to consolidate training and technical assistance from several agencies into a single comprehensive effort.

The ongoing national multisite evaluation of the 45 children=s services projects assesses outcomes for children and their families as well as the development of a service system. The evaluation focuses on assessing children and families, the service system, and the interaction between the two. Descriptive information is obtained on the characteristics of all children and families that enter the service program. In addition, each grant site has a goal of gathering outcome information on a sample of at least 200 children and their families. Based on data collected through May, 1998, using an OMB-approved set of measures, descriptive baseline information was available on over 25,500 children, and six-month functional outcomes were available on over 3,300 children.

Child and Family Characteristics. Among the children entering the service sites, 63% were male, 37% were female. The children=s average age was 12.6 years. White children represented 54% of service recipients, while 22% were Hispanic, 17% were African American, and 7% were classified as Native Americans, Native Hawaiians, or Asian/Pacific Islanders. Among those children assigned a primary diagnosis, 35% had conduct or adjustment disorders, 26% had depressive or dysthymic disorders, 13% had attention deficit or hyperactivity disorders, 7% had anxiety disorders, and 2% had psychotic disorders. The remaining 17% of the children were diagnosed with substance use, developmental disorders, learning disability, other, or, the primary diagnosis was deferred. With respect to family characteristics, children in custody of their mothers represented 48% of the sample, compared to a national average for mother-maintained households of 27%.

Child Outcomes at Six Months. Findings show notable improvements for children after six months in service.

- ***Law Enforcement Contacts Reduced.*** No law enforcement contacts were reported for 44% of the children who had one or more contacts in the 12 months before entering services.

- ***School Grades Improve.*** The percentage of children with average or above average school grades increased by 14%.

- ***Fewer School Absences.*** The percentage of children attending school half or less of the time decreased by 33%.

- ***Mental Health Improves.*** The percentage of children with marked or severe levels of functional impairment was reduced by 33%.

- ***Stable Living Arrangements Increase.*** A single living arrangement was reported for 50% of the children who reported multiple living arrangements in the 12 months before entering services.

A growing source of evidence about the positive changes taking place in children=s service systems is the individual grantee sites which have expanded their evaluations beyond the requirements of the national multisite evaluation. Site-specific findings include:

- ***Money Saved.*** In Milwaukee, Wisconsin, the average monthly cost of caring for a child in the Wraparound Program was $2,800. That was 37% less than the average monthly cost of $4,449 of serving a child in a typical out-of-home residential placement.

- ***Fewer Crimes Committed.*** Based on a two-year study, the Crossroads Program of San Mateo, California, reported a 61% reduction in the number of crimes committed by youth in probation during the 12 months after entering the program compared to the 12 months before entering the program.

- ***Acute Psychiatric Hospitalizations Reduced.*** The program in Sonoma County, California, reported that the average number of acute psychiatric hospitalizations per month among children and youth during 1995 and 1996 was reduced by 34% during 1997. These reductions represented a 48% cost savings.

- ***Children Stay in Their Communities.*** The ACCESS Program in Alexandria, Virginia, showed a 48% reduction in out-of-city residential placements for children with serious emotional disturbance since the program=s inception in 1995.

The experience of administering the Comprehensive Community Mental Health Services for Children and Their Families Program over the past five years also has generated important lessons about method:

- **The contribution of specific clinical treatment interventions to the service system as a whole must be examined as part of determining treatment effectiveness.** The development of effective treatment interventions within service systems must receive as much attention as the development of integration and coordination mechanisms of the service system. Specific quality treatments delivered to children and families in the context of a service system may prove to have a greater impact on child and family outcomes than the service system as a whole. The proposed Treatment Effectiveness Study program under KDA will accomplish this goal. The partnership between this Program and KDA programs strengthens both and provides the best opportunity for evolving increasingly effective services for children and their families.

- **Accountability to families must be included among expected outcomes for effective services.** Children and families who receive services are increasingly demanding that service systems be held accountable to deliver services that meet their needs. Service systems must find ways to increase the involvement of family members in the delivery, management, and evaluation of services. Satisfaction is a key outcome studied in the national evaluation.

- **New evaluation and information system tools must be developed to accommodate Arealworld@ or field conditions as well as the expectations of both customers andresearchers.** Calls for accountability of the service system to the service community require the development of new evaluation methodologies that provide meaningful and timely information about service quality. A critical tool for these new methodologies will be an information system that integrates data effectively and efficiently from collaborating human service agencies. Development of an efficient cross-agency information management system is a key element of infrastructure development under the Program.

- **Managed care practices must be included in any service study.** Service systems must become cost effective, especially when resources are limited. The degree to which service systems adopt managed care practices may very well determine the ability of the systems to deliver much needed services to children and families. Beginning in FY 1998, all new grants are required to address the important relationship between grant programs and managed care practices in the target jurisdiction.

- **Population-based measurement of service impact is needed.** The impact of service systems across the Nation will be largely understood by the degree to which services reduce the mental health needs of children and their families in the general population. Population-based accountability tools will need to be increasingly applied to demonstrate service penetration and its resulting needs reduction. The national evaluation includes development of population-based measurement tools that will measure the extent to which client level outcomes can be generalized to the general population.

Still more can be learned about the specific effects of systems of care. Three grantee sites with mature systems of care were selected to participate in a study to compare their child, family, and system outcomes with the outcomes of non-grantee sites that deliver services as usual. Geographic, demographic, and economic criteria were used to match non-grantee sites with grantee sites. Results of this Comparison Study, which are expected to be reported in the legislatively mandated report to Congress for FY 1999. This report, to be submitted summer FY 1999, will provide critical information on the characteristics of system of care sites that yield better child, family, and system outcomes than sites delivering services as usual.

The Children=s Mental Health Services Program contributes to the achievement of Goal 3--Assure Services Availability/Meet Targeted Needs. See GPRA plan for standard measures and program specific measures, and update data.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE	
1995.....	$58,958,000	---	1996
.....	59,927,000	---	
1997.....	69,896,000	---	
1998.....	72,927,000	---	
1999.....	78,000,000	---	

Rationale for the Budget Request

The FY 2000 President=s Budget proposes a funding level for the Comprehensive Mental Health Services for Children and Their Families program of $78,000,000. This funding level is the same as FY 1999 and will allow the program to continue supporting approximately 51 grants, and will allow continued evaluation of the program in addressing key goals.

B. CENTER FOR MENTAL HEALTH SERVICES
3. Protection and Advocacy Program (P&A)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA	$21,957,000	$22,957,000	$22,957,000	---

2000 Authorization

P.L. 102-173, Section 117.....Expired

Purpose and Method of Operation

The Protection and Advocacy Program for Individuals with Mental Illness Act (PAIMI) authorizes formula grant allotments to be awarded to Protection and Advocacy (P&A) systems that have been designated by the Governor in each of the 50 States, the District of Columbia, and the U.S. Territories. The State P&A programs are mandated to protect the rights of and advocate for the individuals with mental illness and severe emotional disturbance. The allotments are used to investigate allegations of abuse and neglect in public and private facilities such as hospitals, nursing homes, community facilities, board and care homes, homeless shelters, jails and prisons, etc., that care for or treat individuals with mental illness. P&A programs address problems which arise during transport and admission to the institutions, as well as the time of residency in, and 90 days after discharge from them. The P&A systems also pursue legal, administrative and other appropriate remedies to redress complaints of abuse, neglect, and rights violations through activities that ensure the enforcement of the Constitution and Federal and State statutes and regulations. They also are mandated to ensure protection and advocacy for the rights of persons with mental illness.

The most recent data (FY 1997) indicate that PAIMI programs responded to more than 23,000 abuse, neglect and civil rights violations. By utilizing combinations of technical assistance, administrative remedies, negotiation and mediation, the majority of these complaints were resolved. Only 4 percent of the total complaints received needed legal intervention. In addition, PAIMI programs were involved in the following activities: representing approximately 285,636 individuals in class action suits; advocating on behalf of 405 groups (including nearly 1,334,226 persons), e.g., hospital wards and consumer organizations; responding to 62,151 requests for information; and conducting education and training sessions for 73,107 mental health administrators, legislators, P&A staff, other community organizations and mental health system clients and their families.

The Protection and Advocacy Program (P&A) contributes to the achievement of Goal 3--Assure Services Availability/Meet Targeted Needs. See GPRA plan for standard measures and program specific measures, and update data.
Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995	$21,957,000	---
1996	19,850,000	---
1997	21,957,000	---
1998	21,957,000	---
1999	22,957,000	---

Rationale for the Budget Request

The FY 2000 President=s budget proposes to fund the Protection and Advocacy Program at $22,957,000. This funding will allow the program to maintain its activities at the FY 1999 enacted level.

Center for Mental Health Services
Protection & Advocacy Program

State/Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Alabama	$292,440	$307,385	$307,385	---
Alaska	259,782	271,613	271,613	---
Arizona	293,898	314,590	314,590	---
Arkansas	259,782	271,613	271,613	---
California	1,943,380	2,041,368	2,041,368	---
Colorado	259,782	271,613	271,613	---
Connecticut	259,782	271,613	271,613	---
Delaware	259,782	271,613	271,613	---
District of Columbia	259,782	271,613	271,613	---
Florida	897,741	951,267	951,267	---
Georgia	471,288	495,779	495,779	---
Hawaii	259,782	271,613	271,613	---
Idaho	259,782	271,613	271,613	---
Illinois	703,778	731,471	731,471	---
Indiana	375,684	393,073	393,073	---
Iowa	259,782	271,613	271,613	---
Kansas	259,782	271,613	271,613	---
Kentucky	268,843	280,610	280,610	---
Louisiana	300,729	311,827	311,827	---
Maine	259,782	271,613	271,613	---
Maryland	296,184	309,207	309,207	---
Massachusetts	346,002	358,432	358,432	---
Michigan	588,331	629,518	629,518	---
Minnesota	283,885	296,176	296,176	---
Mississippi	259,782	271,613	271,613	---
Missouri	342,993	359,193	359,193	---
Montana	259,782	271,613	271,613	---
Nebraska	259,782	271,613	271,613	---
Nevada	259,782	271,613	271,613	---
New Hampshire	259,782	271,613	271,613	---
New Jersey	441,871	463,140	463,140	---
New Mexico	259,782	271,613	271,613	---
New York	1,040,100	1,072,815	1,072,815	---
North Carolina	477,566	500,214	500,214	---
North Dakota	259,782	271,613	271,613	---

Center for Mental Health Services
Protection & Advocacy Program

State/Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Ohio	706,422	735,314	735,314	---
Oklahoma	259,782	271,613	271,613	---
Oregon	259,782	271,613	271,613	---
Pennsylvania	743,339	768,827	768,827	---
Rhode Island	259,782	271,613	271,613	---
South Carolina	259,782	271,613	271,613	---
South Dakota	259,782	271,613	271,613	---
Tennessee	346,995	363,170	363,170	---
Texas	1,242,120	1,299,717	1,299,717	---
Utah	259,782	271,613	271,613	---
Vermont	259,782	271,613	271,613	---
Virginia	407,025	426,026	426,026	---
Washington	338,921	355,198	355,198	---
West Virginia	259,782	271,613	271,613	---
Wisconsin	327,414	340,093	340,093	---
Wyoming	259,782	271,613	271,613	---
Puerto Rico	469,828	477,560	477,560	---
American Somoa	139,242	145,584	145,584	---
Guam	139,242	145,584	145,584	---
North Mariana Islands	139,242	145,584	145,584	---
Virgin Islands	139,242	145,584	145,584	---
TOTAL, States &Territories	21,517,859	22,497,857	22,497,857	---
Set-Aside	439,141	459,143	459,143	---
TOTAL P&A	$21,957,000	$22,957,000	$22,957,000	---

B. CENTER FOR MENTAL HEALTH SERVICES
4. Projects for Assistance in Transition from Homelessness (PATH)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$23,000,000	$26,000,000	$31,000,000	+$5,000,000

2000 Authorization

PHSA Section 535 (a).....Expired

Purpose and Method of Operation

The Projects for Assistance in Transition from Homelessness (PATH) program was established in FY 1991 as a formula grant program to distribute Federal funds to each State, the District of Columbia, and the U. S. Territories to provide services to individuals with severe mental illness, as well as to individuals with severe mental illness and co-occurring substance abuse disorders, who are homeless or at risk of becoming homeless. Eligible services funded include: outreach; screening and diagnostic treatment; habilitation and rehabilitation; community mental health services; alcohol or drug treatment (for mentally ill individuals with co-occurring substance use disorders); staff training; case management; supportive and supervisory services in residential settings; and referrals for primary health care, job training, and education. In addition, to improve coordination of services and housing for the target population, a limited set of housing services may be funded.

PATH delegates to States responsibility to determine their own priorities from among the wide array of eligible services. Under PATH, States are encouraged to develop and implement outcome measures and have considerable flexibility to determine goals, objectives and outcomes. The PATH program requires matching funds of $1 to every $3 of federal funds. In 1996, State and local matching funds were more than twice as much as the required amount.

The PATH program contributes to, and benefits from, the CMHS: Knowledge Development and Application strategy. PATH funded programs serve both as sources and recipients of knowledge concerning exemplary practices in the delivery of mental health services for the homeless.

Clients Served: The most recent program data indicate that in FY 1996, 380 local agencies and/or counties received PATH funding. A total of 76,000 clients were served, with adults in the age range 18-64 comprising 93 percent of the caseloads. Of the clients served, 40 percent were African-American; 8 percent were of Hispanic origin. Persons receiving PATH-funded services have some of the most disabling

mental disorders. For the States reporting diagnostic information, the most common diagnoses were affective disorders (37 percent), followed by schizophrenia and other psychotic disorders (34 percent). Sixty six percent of clients served had a co-occurring substance use disorder in addition to a serious mental illness.

The Projects for Assistance in Transition from Homelessness (PATH) Program contributes to the achievement of Goal 3--Assure Services Availability/Meet Targeted Needs. See GPRA plan for standard measures and program specific measures, and update data.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995	$29,462,000	---
1996	20,000,000	---
1997	20,000,000	---
1998	23,000,000	---
1999	26,000,000	---

Rationale for the Budget Request

The proposed funding for this program in FY 2000 is $31 million, an increase of $5 million (19%) over the FY 1999 appropriation. States will use these resources to provide additional outreach services and to enroll more people into mainstream services. For FY 2000 PATH expects to: increase the number of persons contacted from 102,000 to 115,000; improve targeting of services to those most in need; and increase the percentage of persons contacted who become enrolled clients from 30% to at least 33%, and increase the number of participating agencies that offer outreach services from 70% to 80%.

Center for Mental Health Services
PATH Program

State or Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Alabama	$300,000	$300,000	$300,000	---
Alaska	300,000	300,000	300,000	---
Arizona	300,000	314,000	409,000	95,000
Arkansas	300,000	300,000	300,000	---
California	2,381,000	3,015,000	3,920,000	905,000
Colorado	300,000	300,000	366,000	66,000
Connecticut	300,000	300,000	378,000	78,000
Delaware	300,000	300,000	300,000	---
District of Columbia	300,000	300,000	300,000	---
Florida	952,000	1,205,000	1,567,000	362,000
Georgia	305,000	386,000	502,000	116,000
Hawaii	300,000	300,000	300,000	---
Idaho	300,000	300,000	300,000	---
Illinois	793,000	1,004,000	1,305,000	301,000
Indiana	300,000	319,000	415,000	96,000
Iowa	300,000	300,000	300,000	---
Kansas	300,000	300,000	300,000	---
Kentucky	300,000	300,000	300,000	---
Louisiana	300,000	300,000	343,000	43,000
Maine	300,000	300,000	300,000	---
Maryland	335,000	424,000	551,000	127,000
Massachusetts	442,000	560,000	728,000	168,000
Michigan	544,000	688,000	895,000	207,000
Minnesota	300,000	300,000	365,000	65,000
Mississippi	300,000	300,000	300,000	---
Missouri	300,000	329,000	428,000	99,000
Montana	300,000	300,000	300,000	---
Nebraska	300,000	300,000	300,000	---
Nevada	300,000	300,000	300,000	---
New Hampshire	300,000	300,000	300,000	---
New Jersey	620,000	785,000	1,021,000	236,000
New Mexico	300,000	300,000	300,000	---
New York	1,320,000	1,671,000	2,173,000	502,000
North Carolina	300,000	300,000	387,000	87,000
North Dakota	300,000	300,000	300,000	---

Center for Mental Health Services
PATH Program

State or Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Ohio	622,000	788,000	1,025,000	237,000
Oklahoma	300,000	300,000	300,000	---
Oregon	300,000	300,000	300,000	---
Pennsylvania	674,000	853,000	1,110,000	257,000
Rhode Island	300,000	300,000	300,000	---
South Carolina	300,000	300,000	300,000	---
South Dakota	300,000	300,000	300,000	---
Tennessee	300,000	300,000	341,000	41,000
Texas	1,063,000	1,346,000	1,751,000	405,000
Utah	300,000	300,000	300,000	---
Vermont	300,000	300,000	300,000	---
Virginia	358,000	453,000	590,000	137,000
Washington	301,000	381,000	495,000	114,000
West Virginia	300,000	300,000	300,000	---
Wisconsin	300,000	300,000	379,000	79,000
Wyoming	300,000	300,000	300,000	---
Puerto Rico	300,000	300,000	327,000	27,000
American Somoa	50,000	50,000	50,000	---
Guam	50,000	50,000	50,000	---
North Mariana Islands	50,000	50,000	50,000	---
Virgin Islands	50,000	50,000	50,000	---
Total, States & Territories	22,310,000	25,221,000	30,071,000	4,850,000
Set-Aside	690,000	779,000	929,000	150,000
TOTAL, PATH	$23,000,000	$26,000,000	$31,000,000	$5,000,000

B. CENTER FOR MENTAL HEALTH SERVICES
5. Mental Health Block Grant (MHBG)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$275,420,000	$288,816,000	$358,816,000	+$70,000,000

2000 Authorization

Mental Health Block Grant .....Expired

Purpose and Method of Operation

The Mental Health Block Grant (MHBG) supports comprehensive, community-based systems of care for adults with a serious mental illness (SMI) and children with serious emotional disturbances (SED). Grants are awarded to States and Territories based on a legislated formula (described below). States are required to develop annual plans with input from State Planning Councils and must include goals, objectives, and performance indicators. This process enables States to better meet the unique needs of their SMI and SED populations. Examples of populations served by Block Grant supported community-based programs include, but are not limited to:

Adults with severe mental illness

(1) who have a history of repeated psychiatric hospitalizations or repeated use of intensive community services
(2) are dually diagnosed with mental illness and substance abuse,
(3) have a history of interactions with the criminal justice system, including arrests for vagrancy and other misdemeanors, or
(4) are currently homeless.

Children with serious emotional disturbance who:

(1) are at risk of out-of-home placement,
(2) are dually diagnosed with serious emotional disturbance and substance abuse, or
(3) as a result of their disorder are at high risk for the following significant adverse outcomes: attempted suicide, parental relinquishment of custody, a brush with the law, behavior dangerous to self or others, running away or being homeless.

By way of *Set-Aside Funds* the MHBG also supports national data collection and technical assistance activities on mental health issues of local and national importance. A mandatory 5 percent set-aside is used

to support technical assistance, data collection and evaluation to the States and in recent years, standards development for performance-based managed care has been a top priority. The set-aside funding is used to established a partnership between CMHS and the States to help:

- **$** improve effectiveness and cost efficiency of mental health services delivery;
- **$** evaluate the quality and efficiency of State and local service programs;
- **$** respond to changes in the financing and delivery of mental health services; and
- **$** increase involvement of consumers and family members in all aspects of services.

Technical Assistance: The Center provides on-site technical assistance to States and regions on all issues of importance to mental health planning, service delivery, and evaluation. CMHS supports special mental health-related projects and events, including regional and national conferences; offers State mental health authorities, consumers, families, and State planning councils the resources of a comprehensive library of resource materials; communicates electronically with the mental health community through the World Wide Web and a forum on the National Mental Health Knowledge Exchange Network; maintains a database of expert consultants; and publishes a quarterly newsletter. CMHS also supports technical assistance and analysis focusing on special populations or service issues. Recent activities include analysis and technical assistance related to the elderly population, development of cultural competence standards for managed care systems, and development of training protocols for behavioral health professionals working in primary care settings.

Technical assistance can come in the form of a publication, national meeting etc. For example, on September 15, 1998, CMHS and CSAT released the results of a major study of national expenditures for mental health, alcohol, and other drug abuse treatment. This study, which is the first major update of spending estimates since those published by Rice et al. in 1990, is the result of a collaboration between the managed care offices in the two centers. Estimates are presented by payer and type of provider for 1996, and trends since 1986 are identified. In addition, the study provides estimates that allow direct comparison with those published by HCFA for all health care.

A key finding from the study indicated that of the total $79.3 billion spent nationally on treatment of mental health and abuse of alcohol and other drugs, $66.7 billion was for treatment of mental illness. Other key findings from the study were published in the September/October, 1998 issue of Health Affairs. The full report, National Expenditures for Mental Health, Alcohol and Other Drug Abuse Treatment, 1996, is available from the CMHS Knowledge Exchange Network. Unlike previous studies, CMHS and CSAT intend to update these estimates annually, to ensure that information on national spending for MH/SA services is kept current.

Data Collection/Essential National Benchmark Information: The National Reporting Program collects essential information on the organization, financing, and operation of mental health organizations, general hospital psychiatric services, and managed behavioral healthcare organizations. Such information covers both public and private systems of care. To examine changes in the types of persons served, surveys of

consumer characteristics and service use are conducted periodically. Special projects have been undertaken to examine the availability and use of mental health services in all types of criminal justice settings, and in consumer-operated self-help programs. Numerous requests are received by this program for benchmark statistical information. A biennial publication, Mental Health, United States, is prepared to examine key policy issues in the field and to provide a compilation of statistical information.

Data Collection/Information Infrastructure: To respond to the needs for improved quality tools, the Mental Health Statistics Improvement Program is currently engaged in several initiatives. These include a project to define a new, consensually based information system for mental health that incorporates population data as well as services, outcome, and performance indicator information. A second project tests the feasibility of a Consumer-Oriented Report Card for behavioral healthcare plans. A third project pilots a set of performance indicators for the State mental health agencies as described immediately below.

Data Collection/Partnership for Planning and Performance: Over time, an increasing awareness has developed regarding the critical importance of accountability. To successfully meet the needs of persons with mental illness, States and others must be able to document that funds have been expended carefully and that desired effects have been achieved. The Partnership for Planning and Performance project will enhance the management and reporting capacity of States and will serve as a starting point for comparability of performance indicators among State mental health systems. The project will provide necessary lessons for CMHS to use in considering accountability for State systems in the future. The project has three phases: feasibility assessment, pilot testing, and implementation. Phase one of this project, feasibility assessment, is completed and awards to 16 States for the phase two pilot of performance indicators were made in FY 1998.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE	
1995	$277,919,000	11	1996
275,420,000	11		
1997	275,420,000	11	
1998	275,420,000	11	
1999	288,816,000	11	

Data Elements Used to Calculate State Allotments

FY 1999: The 1999 State allotments under the Block Grant were determined after implementing the minimum allotment provisions of the Appropriation Act for fiscal year 1999. Section 218 of Public Law 105-277 permitted the Secretary to implement current law including the change to the use of non-

manufacturing wages, but established minimum allotments. The general principle of the minimum allotments was that no State would be allotted less than the amount they received in fiscal year 1998.

The 1999 State allotments were generated using the following factors:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA website, Personal Income by State and Region, for years 1994-1996.

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, Annual Time Series of Population Estimates by Age and Sex, By Single Year of Age and Sex, data as of 7/1/1996.

- Total Taxable Resources (TTR) for years 1994-1996 - Office of Economic Policy, Department of the Treasury, provided directly to OAS.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were included in the 1990 census.

- A Cost of Services Factor which includes the following: Fair Market Rents for the Section 8 Housing Assistance Payments Program **C** Fiscal year 1997, from the U.S. Department of Housing and Urban Development, *Federal Register*, September 20, 1996, Vol. 61, No. 184, pages 49576-49635, from website *http://www.hud.gov* and then *ftp@ftp.aspemsys.com*. 1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1993 hourly hospital wages developed from the FY 1997 HCFA Hospital Inpatient Prospective Payment System Wage Rates [published in the *Federal Register*, August 30, 1996, Vol. 61, Number 170, pages 46165-46215 with corrected data published in the *Federal Register* December 19, 1996, Vol. 61, Number 245, pages 66919-66923] in the HCFA public use file AHCFA Hospital Wage Index Survey File@ of Hospital Inpatient Prospective Payment System FY 1997 Rates downloaded from website *http://www.hcfa.gov/stats/pufiles.htm* and corrected per the December 1996 revisions.

FY 2000: Since the minimum allotment provisions of P.L. 105-277 applied only to fiscal year 1999 funds, State allotments for FY 2000 will be determined using current law including the use of non-manufacturing wage data in calculating the cost of service factor. The factors that were used in producing the FY 2000 table are:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA website *http://www.bea.doc.gov/bea/dr/spitbl-d.htm#table2* - Table 2, Personal Income by State and Region, 1993-1997, release date 9/14/98, also available from *http://www.bea.doc.gov/bea/ar1098rem/table1.htm.*

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, text file AG9797.txt, 1990-to-1997 Annual Time Series of Population Estimates by Age and Sex, By Single Year of Age and Sex, public release date 7/21/98. Census website is *http://www.census.gov/population/estimates/state/stats/ag9797.txt*. (data as of 7/1/97).

- Total Taxable Resources (TTR) - Office of Economic Policy, Department of the Treasury, provided directly to OAS via e-mail, filename NM98EST.wk4, release date 9/30/98, Total Taxable Resources, 1994-1996.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were included in the 1990 census.

- A Cost of Services Factor which includes the following: Fair Market Rents for the Section 8 Housing Assistance Payments Program **C** Fiscal year 1997, from the U.S. Department of Housing and Urban Development, *Federal Register*, September 20, 1996, Vol. 61, No. 184, pages 49576-49635, from website *http://www.hud.gov* and then *ftp@ftp.aspemsys.com*. 1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1993 hourly hospital wages developed from the FY 1997 HCFA Hospital Inpatient Prospective Payment System Wage Rates [published in the *Federal Register*, August 30, 1996, Vol. 61, Number 170, pages 46165-46215 with corrected data published in the *Federal Register* December 19, 1996, Vol. 61, Number 245, pages 66919-66923] in the HCFA public use file AHCFA Hospital Wage Index Survey File@ of Hospital Inpatient Prospective Payment System FY 1997 Rates downloaded from website *http://www.hcfa.gov/stats/pufiles.htm* and corrected per the December 1996 revisions.

The Mental Health Block Grant contributes to the achievement of Goal 3--Assure Services Availability/Meet Targeted Needs. See GPRA plan for standard measures and program specific measures. Baseline and update data are not yet available, but outcome data will be collected on a voluntary basis in the FY 1999 Block Grant application.

Rationale for the Budget

The FY 2000 President=s budget proposes that the Mental Health Block Grant be funded at $358,816,000, an increase of $70,000,000 over the FY 1999 enacted level. This level of funding will assure that each State will receive an increase over their FY 1999 allotment. This increase will reinvigorate the State systems of community based care and help States expand services to respond to the continuing unmet need of adults with serious mental illness and children with serious emotional disturbances. Every night, about 200,000 people with major mental illness are homeless; and each year, more than 1 million youth come in contact with the juvenile justice system. Reports indicate that these unmet mental health needs result in costs to the nation that are equal to costs for cancer or heart disease.

The infusion of these additional funds will be critical in enabling State mental health authorities to significantly influence efforts to reorganize health care delivery systems to ensure sufficient access to quality mental health care for underserved populations. The increase will help States with the cost of new medications and treatment modalities, school violence abatement programs, jail diversion programs for youths, post incarceration and post hospitalization community service programs, and community-based suicide prevention programs for youths and the elderly. This increase will allow States and communities to focus on gaps between needs and services, such as case management or school based services for persons who do not meet criteria for other funding streams, yet for whom services would prevent suffering and increased expenditures at later points of entry for care. States will be better equipped to respond to mental health needs of persons moving from welfare-to-work as a result of welfare reform legislation and to co-occurring disorders among individuals with mental heath and substance abuse problems.

Service Expansion

There are numerous communities within the States and Territories that will be able to begin to address their needs by expanding their comprehensive community based services to adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED). States will be able to expand the access and availability of rehabilitation, employment, housing, educational, medical, health, mental health, and other support services. Outreach and services to homeless individuals with SMI and persons residing in rural areas will also be expanded with additional funds. The expansion of the comprehensive community-based mental health service system will allow for further reduction in the numbers of individuals residing in inpatient or residential institutions and allow them to function in the community to the maximum extent of their capabilities.

Additionally, this increased funding will provide essential mental health services for adults and children. Research has indicated that provisions of basic services such as physician and medication, alone, generally are not effective. The services listed below are among those which have demonstrated success with our Nation=s children and adults living with a serious mental disorder. Knowledge being gained from the KDA

programs is finding a natural home in the Mental Health Block Grant Program being implemented in States across the Nation.

For Adults:

- assertive community treatment, including the Program of Assertive Community Treatment (PACT)
- hospital discharge planning, beginning the day of admission and including the involvement of the individual=s community case manager,
-- psychiatric rehabilitation,
-- integrated mental health and substance abuse treatment for those with dual diagnosis,
-- case management, including assistance obtaining affordable and appropriate housing in community settings, income support and other benefits,
-- consumer peer support programs,
-- consumer-run drop-in and other community programs,
-- family education and training on management of mental illness and on available services,
-- medication education and management,
-- in collaboration with criminal justice agencies, programs to identify and refer persons with serious mental disorders to appropriate community-based service providers following contact with the law,
-- mental health treatment for welfare recipients making the transition from welfare to work as a result of welfare reform legislation, and
-- other evidenced-based service interventions or innovative services.

For Children:

-- day treatment programs (school-based and free-standing),
-- school-based mental health services, including crisis services, mental health consultation for teachers and administrators, behavioral aides and other services, except that such funds shall not be used for services covered under a child=s Individualized Education Program through the Individuals with Disabilities Education Act,
-- intensive in-home services,
-- behavioral aides and community mentors,
-- family education and training on management of serious emotional disturbance and on available services,
-- crisis mental health services,
-- family support services,
-- family respite care services,
-- case management, and
-- other wraparound services designed to keep the child safely in the home or, if appropriate, other community setting, e.g., transportation, housing, child care.

Criminal Justice Issues and Mental Health

The sheer magnitude of people with serious psychiatric disorders entering jails is staggering. On an average day, between 9% of men and 18.5% of women entering local jails have a history of serious mental illness, a rate higher than that of the general population and of the general prison population.[4] Because of the rapid turnover in the jail population, this translates into nearly 700,000 admissions to jails annually constituting people with serious mental disorders. Fewer than one-half (48%) of jails work with community mental health centers in providing mental health services. States need additional Block Grant funding for discharge planning and to ensure post incarceration, community-based services to individuals exiting local jails and prison systems.

Welfare Reform

Welfare reforms for some people are resulting in increasing poverty and family stress without supporting and strengthening a family=s psychological resources. Such reforms too often have negative consequences on family members, especially children. An increase in the Mental Health Block Grant can help provide basic psychological support services to independent adults and families, through collaboration with public welfare systems and other human services, to thwart the intensification of stressors associated with the transition to living without public welfare benefits.

Co-Occurring Disorders

Additional Block Grant funding will be of particular help to States as they try to respond to the growing problem of persons with both mental health and substance abuse disorders. A national survey has found that 8 to 11 million people have both a mental health and substance related problem. Alcohol-use disorders and/or drug abuse conditions commonly occur in people with other severe mental illnesses, such as schizophrenia or bipolar disorder; and can exacerbate their psychiatric, medical and family problems. Block Grant funds will be used by States to more effectively improve detection of alcohol-related and drug abuse problems, establish diagnoses, and develop appropriate treatment plans for persons with severe mental illness.

Set-Aside Funds for Technical Assistance and Data Collection

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[4] Teplin, LA; Abram, K.M.; and mcCelland, G.M. (1996) Prevalence of psychiatric disorders among incarcerated women. Archives of General psychiatry. 53:505-11.

Additional block grant funds will provide funds for continuing and new technical assistance activities and data collection. For example, studies and policy analyses both point to a precipitous decline in the availability of financial resources for mental health services. This decline, in part, may be attributed to the greater accountability now required by payers for the resources they expend. Since the mental health field does not have consensually agreed upon quality tools -- practice guidelines, outcome measures , report cards, and performance indicators -- those negotiating managed care contracts cannot document quality and outcome of care for payers. As a result, payers have reduced their behavioral healthcare benefit costs 54 percent between 1988 and 1997 -- a cut of 670 percent more than cuts taken by general healthcare benefit costs. To address this, additional set-aside funds will continue to support and expand the collection of essential national benchmark information, the development of information infrastructure, and partnership for planning and performance activities.

Substance Abuse and Mental Health Services Administration

Community Mental Health Services Block Grant, FY 1998-2000

State / Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Alabama	$3,875,371	$3,971,612	$5,289,314	$1,317,702
Alaska	429,159	588,437	721,492	133,055
Arizona	3,870,297	4,579,039	5,779,821	1,200,782
Arkansas	2,232,840	2,316,177	3,008,799	692,622
California	34,513,517	35,155,183	46,535,232	11,380,049
Colorado	3,750,325	3,750,325	4,347,331	597,006
Connecticut	3,241,039	3,241,039	4,025,643	784,604
Delaware	730,894	730,894	808,105	77,211
District Of Columbia	596,523	596,523	726,105	129,582
Florida	12,239,345	15,386,850	20,162,974	4,776,124
Georgia	6,194,485	7,389,430	9,741,379	2,351,949
Hawaii	1,243,596	1,243,596	1,506,808	263,212
Idaho	1,070,863	1,070,863	1,389,768	318,905
Illinois	11,194,433	11,194,433	13,557,580	2,363,147
Indiana	6,332,808	6,332,808	7,074,787	741,979
Iowa	2,740,750	2,740,750	3,095,824	355,074
Kansas	2,374,949	2,374,949	2,789,115	414,166
Kentucky	3,670,758	3,733,632	4,874,405	1,140,773
Louisiana	4,376,363	4,376,363	5,331,372	955,009
Maine	1,265,584	1,265,584	1,511,891	246,307
Maryland	5,707,845	5,707,845	7,006,130	1,298,285
Massachusetts	6,360,517	6,360,517	7,548,019	1,187,502
Michigan	10,771,969	10,771,969	11,725,962	953,993
Minnesota	4,438,360	4,438,360	4,934,026	495,666
Mississippi	2,456,254	2,531,443	3,302,968	771,525
Missouri	4,797,839	4,797,839	5,910,467	1,112,628
Montana	873,926	873,926	1,036,533	162,607
Nebraska	1,300,783	1,367,377	1,740,914	373,537
Nevada	1,450,044	1,689,409	2,202,414	513,005
New Hampshire	1,154,144	1,154,144	1,290,056	135,912
New Jersey	8,090,233	8,107,027	10,383,870	2,276,843
New Mexico	1,426,307	1,490,170	1,887,309	397,139
New York	17,669,287	18,640,661	23,953,168	5,312,507
North Carolina	6,238,341	6,498,831	8,550,899	2,052,068
North Dakota	548,729	579,458	740,843	161,385
Ohio	12,772,348	12,772,348	12,946,890	174,542
Oklahoma	3,049,628	3,049,628	3,927,023	877,395
Oregon	3,228,481	3,228,481	3,770,612	542,131
Pennsylvania	12,024,336	12,024,336	14,525,618	2,501,282
Rhode Island	895,462	1,013,252	1,294,391	281,139

Community Mental Health Services Block Grant, FY 1998-2000

State / Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
South Carolina	3,386,545	3,451,050	4,529,118	1,078,068
South Dakota	579,888	611,875	785,512	173,637
Tennessee	4,613,933	4,896,610	6,454,889	1,558,279
Texas	16,264,840	19,588,185	25,520,651	5,932,466
Utah	1,579,290	1,654,986	2,222,499	567,513
Vermont	611,017	611,017	694,117	83,100
Virginia	6,162,479	6,982,802	8,988,622	2,005,820
Washington	6,001,118	6,001,118	7,196,398	1,195,280
West Virginia	1,941,957	1,941,957	2,264,098	322,141
Wisconsin	5,001,980	5,001,980	5,737,161	735,181
Wyoming	382,485	382,485	413,150	30,665
State Sub-total	**257,724,264**	**270,259,573**	**335,762,072**	**65,502,499**
American Samoa	50,000	50,000	59,238	9,238
Guam	128,389	134,969	168,636	33,667
Northern Marianas	50,000	50,000	54,896	4,896
Puerto Rico	3,396,063	3,570,111	4,460,636	890,524
Palau	50,000	50,000	50,000	0
Marshall Islands	50,000	50,000	56,657	6,657
Micronesia	102,115	107,349	134,125	26,777
Virgin Islands	98,168	103,199	128,940	25,742
Territory Sub-total	**3,924,735**	**4,115,628**	**5,113,128**	**997,500**
SAMHSA Set-Aside	**13,771,001**	**14,440,799**	**17,940,800**	**3,500,001**
GRAND TOTAL	**$275,420,000**	**$288,816,000**	**$358,816,000**	**$70,000,000**

C. CENTER FOR SUBSTANCE ABUSE PREVENTION

Overview

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA	$405,920,000	$465,150,000	$444,850,000	-$16,300,000

The impact of substance abuse reaches deep into the very fiber of this Nation. It is not only a social issue, but also a public health problem that dramatically affects both the individual and the public. Substance abuse is implicated in violence for both perpetrators and victims; vehicular and job related accidents and crashes; teenage pregnancies; drug exposed infants; suicide; and HIV/AIDS. A study released by the National Institutes of Health in 1998 estimates that the economic cost of alcohol and drug abuse was $246 billion in 1992, the most recent year for which sufficient data were available. This estimate represents $965 for every man, woman, and child. The enormous damage done to society by alcohol- and drug- related problems clearly underscores the need to redouble efforts to prevent substance abuse.

There is strong evidence that substance abuse prevention programs have been effective in reducing drug abuse among youth. This has been demonstrated by CSAP=s own prevention initiatives and by national survey data which indicate that drug use rates have declined to about half of what they were in the late 1970's. Based on the preliminary results of the 1997 National Household Survey on Drug Abuse, there were about 13.9 million current users (or 6.4 percent of the total population) of any illicit drugs, which was down from 25 million (or 17.5 percent of the population) during the peak year of 1979. Sixty percent of the (1997) current users reported marijuana use only. Further, in the 1980's, fewer than 1 in 13 high school students indicated no lifetime use of drugs. In the most recent surveys, nearly one out of five of all 12th graders now report no lifetime use -- an increase of 250 percent.

Even with this dramatic multi-year drop in overall use, there have been significant increases in drug use rates among youth since 1992 and the overall number of users remains too high. Among the 12 and older population, 35% have use an illegal drug in their lifetime. This includes nearly a quarter of our 8th graders and about half of all high school seniors who have tried marijuana. The most recent surveys (1996 and 1997) are showing significant improvements in attitudes toward drug use, including the perception of harm and peer disapproval, and this has been accompanied by a leveling off in the actual rates of drug use. Similarly, the national youth surveys have shown increased use of alcoholic beverages in recent years, but the 1997 High School Senior Survey registered slight declines in alcohol use.

Demographics point to a surge in the youth population -- the 12-20 year old group will increase by 21% in the next fifteen years. This translates into an additional 6.75 million youth needing age- and culturally-

appropriate substance abuse prevention services. Even if the rates of youth drug use remain constant, there will be many more drug-related problems due simply to the growing number of 12-20 year olds. The impact in measures of drug related violence, HIV incidence, academic failure, unemployability, and other areas will be severe without adequate substance abuse prevention programming.

The Center for Substance Abuse Prevention (CSAP) is the lead public health agency responsible for reducing and/or eliminating substance abuse and related problems among the American public. Effective substance abuse prevention addresses all age groups and populations, but CSAP places particular emphasis on our youth who are particularly vulnerable. CSAP also places special attention on the unique needs of diverse populations and groups that have been identified as being at higher levels of risk for substance abuse.

It is important to emphasize that the success of prevention is really the absence, rather than the manifestation, of a behavior (substance abuse) and, as such, is not as simple to measure as tabulating increases or decreases in, for example, the number of beds (health care utilization) or reduction in the size of waiting lists for treatment. Substance abuse prevention, like other health promotion/disease prevention efforts, often must target those risk and resiliency factors found to be associated with later substance abusing behavior.

CSAP's principal role is to serve as the critical bridge in translating research findings into best practices and facilitating their practical application with the intended outcome of improving the quality of prevention services as well as the availability of effective substance abuse prevention programs within the States and communities. The activities carried out in support of this mission are all congruent with the SAMHSA Program Goals described in the GPRA Performance Plan. In addition, the majority of CSAP=s activities are in support of Goal 1 of the National Drug Control Strategy -- To educate and enable America=s youth to reject illegal drugs as well as alcohol and tobacco. In addition, CSAP's workplace programs are in support of Goal 3, Objectives 3 and 4 of the National Drug Control Strategy.

CSAP carries out its mission in three key ways:

Identify best practices and improve prevention outcomes -- The Knowledge Development and Application programs are the primary mechanism through which CSAP identifies, tests and evaluates prevention practices for diverse populations in real-life environments and fosters implementation of best practices by States and community-based providers. It is through these efforts that CSAP facilitates practical, cost-effective, systematic improvements in the quality of substance abuse prevention programming. Knowledge Development programs support targeted, short-term, practical services research studies of questions that have emerged within the professional community. Results from these behavioral and applied studies fill gaps in prevention knowledge, lead to the identification of best practices and ultimately to improved services and service outcomes for recipients of prevention services. Knowledge Application programs synthesize, translate, and disseminate best practices to the field and promote their use

in States and local communities through technical assistance and training. Knowledge Application programs facilitate improved service quality and client outcomes by integrating scientific findings into local practice. These programs address GPRA Goal 1: Bridge the gap between knowledge and practice, and GPRA Goal 2: Promote the adoption of best practices.

Address Critical, Targeted Prevention Capacity Needs - Program data shows that substance abuse prevention does work. There are, however, always new trends or critical issues facing prevention service providers that current State and local capacity cannot meet. Current data from the National Household Survey on Drug Abuse and Monitoring the Future clearly show the depth and breadth of the need for prevention services across populations and geographic areas. Use and risk factors associated with later use are on the rise. State resources are not always adequate to meet these emerging needs. A critical example is the recent statistics from CDC=s 1997 and 1998 HIV/AIDS Surveillance Reports which show an alarming increase in the incidence of HIV/AIDS among African American and Latino males and females. CSAP=s Targeted Capacity programs provide States and communities with resources to address not only the immediate capacity need but also to ensure that programs implemented in doing so use the best prevention practices available. These programs address GPRA Goal 3: Assure services availability/meet targeted needs; and GPRA Goal 2: Promote the adoption of best practices.

Strengthen Federal/State/Community Partnerships -- CSAP continues to work in partnership with other Federal agencies, States, and community providers to strengthen and promote comprehensive prevention programs. In particular, CSAP has pioneered in efforts to work with its strategic partners, by collaborating with the States and national prevention organizations, in the design and operationalization of a National Prevention System (NPS). The Strategic Plan for the NPS consists of actions to reduce those barriers which may inhibit communities from selecting and implementing effective prevention services and policies in our rapidly changing health care environment. In this way, CSAP and the NPS play a pivotal role as an agent of change in helping improve identification of service gaps and more effective utilization of our prevention resources by communities. Another key element of this Federal/State/community partnership is the 20% prevention setaside within the Substance Abuse Performance Partnership Block Grant. Through this mechanism, CSAP and the States can effect significant and cost effective improvements in the substance abuse prevention field through the implementation of Abest practices@ learned through CSAP=s KD&A program. These activities address GPRA Goal 3: Assure services availability/ meet targeted needs; and GPRA Goal 4: Enhance service system performance.

FY 2000 Agenda

The FY 2000 budget reflects CSAP=s commitment in moving the substance abuse prevention field forward into the 21st century. Its program agenda and portfolio continue to build on the strengths of our current programs and progress in identifying and implementing best practices and addressing critical prevention capacity needs of States and communities.

CSAP will support approximately four new State Incentive Grants within its Targeted Capacity Expansion Program.

CSAP will continue its efforts to broaden and strengthen a national substance abuse prevention system that is coordinated, comprehensive, integrated, and performance-based. It is through these efforts that CSAP will be able to effect real, systemic changes which result in improved substance abuse prevention outcomes.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Center for Substance Abuse Prevention

Detail Budget

(dollars in thousands)

	FY 1998 Actual		FY 1999 Enacted		FY 2000 Request	
Prevention KDA:	**No.**	**Amt.**	**No.**	**Amt.**	**No.**	**Amt.**
Grants:						
Continuations	81	$31,878	34	$10,516	131	$15,459
Competing:						
New	18	1,238	130	18,400	---	---
Supplements:						
Administrative	---	---	---	1,500	---	---
Subtotal, Grants	99	33,116	164	30,416	131	15,459
Cooperative Agreements:						
Continuations	28	12,120	47	20,789	38	12,679
Competing:						
New	25	11,520	---	---	---	---
Subtotal, Coop. Agreements	53	23,640	47	20,789	38	12,679
Contracts	15	27,565	15	27,512	13	24,579
Total, Prevention KDA	**167**	**84,321**	**226**	**78,717**	**182**	**52,717**
Targeted Capacity Expansion:						
Grants:						
Continuations	---	---	---	---	61	7,500
Competing:						
New	---	---	61	7,500		
Subtotal, Grants	---	---	61	7,500	61	7,500
Cooperative Agreements:						
Continuations	10	21,204	25	63,101	22	56,011
Competing:						
New	15	41,199	2	5,000	4	12,090
Subtotal, Coop. Agreements	25	62,403	27	68,101	26	68,101
Contracts	3	4,276	2	2,682	2	2,682
Total, Prevention TCP	**28**	**66,679**	**90**	**78,283**	**89**	**78,283**
High Risk Youth:						
Cooperative Agreements:						
Continuations	---	---	13	5,980	15	7,000
Competing:						
New	13	5,954	3	1,020	---	---
Subtotal, Cooperative Agreements	13	5,954	16	7,000	15	7,000
Contracts	---	46	---	---	---	---
Total, High Risk Youth	**13**	**6,000**	**16**	**7,000**	**15**	**7,000**

C. CENTER FOR SUBSTANCE ABUSE PREVENTION
1. Knowledge Development and Application (KDA) Program

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$84,321,000	$78,717,000	$52,717,000	-$26,000,000

2000 Authorization
PHSA Section 501 ..... Indefinite

GPRA Goal 1 -- Bridge the gap between knowledge and practice
GPRA Goal 2 -- Promote the adoption of best practices

Purpose and Method of Operation

CSAP=s Knowledge Development and Application (KDA) efforts reflect a comprehensive and balanced portfolio of programs intended to develop and facilitate the use of practical knowledge generated from prevention theory, methods development, controlled trials, and other avenues of inquiry. This program is the principal mechanism through which CSAP identifies effective approaches in preventing substance abuse and implements its primary mission in bridging the gap between research and practice.

CSAP=s *knowledge development* efforts field test effective research-based models with diverse populations and in unique settings to determine whether they are generalizable and effective in reducing substance abuse with a large number of youth and families in this country. They are focused on children, adolescents and adults and encompass prevention strategies aimed at individuals, families, communities, schools and workplaces. CSAP=s grantee programs are rigorously evaluated to determine scientifically whether research-based prevention programs remain effective when implemented by community providers in real world settings with diverse populations. CSAP=s knowledge development portfolio currently consists of the following programs: 1) the Developmental Predictor Variables Study; 2) the Starting Early Starting Smart Program; 3) the Children of Substance Abusing Parents Study; 4) the Parenting Adolescents and Welfare Reform Study; 5) the Aging, Mental Health and Substance Abuse in Primary Care Program; 6) the Workplace and Managed Care Program; 7) Community-Initiated Prevention Interventions; 8) Alcohol and Youth Studies; 9) Strengthening Families; and 10) the Women and Violence Study.

Through CSAP=s *knowledge application* programs, results from these projects are synthesized, translated and transferred to the States and local communities who are helped to adopt and use identified best practices in their prevention practices. Once found effective, these prevention programs can be recommended to communities and States for implementation with State block grant or local funding. CSAP=s major knowledge application programs include: the High Risk Youth Databank National Register of Effective Programs; Prevention Enhancement Protocol System; National Center for the Advancement of Prevention; the Faculty Development Program; Federal Drug Free Workplace and Laboratory Certification Programs; Conference Grants; Public Education Efforts and Media Campaigns; Parenting is Prevention; the National Clearinghouse for Alcohol and Drug Information; and RADAR Centers and PREVline for the round-the-clock exchange of information.

CSAP=s KDA discretionary programs build the knowledge base in substance abuse prevention, make research findings user-friendly, and promote the wide dissemination of research-based models to the prevention field. The KDA program works in tandem with CSAP=s Targeted Capacity Expansion and Block Grant programs. All KDA programmatic efforts are interdependent and critical elements of the research to practice continuum. They are described in more detail below:

1. Bridge the gap between knowledge and practice -- Knowledge Development

CSAP=s Knowledge Development (KD) efforts build a solid foundation of information about effective strategies to prevent substance abuse and related problems. CSAP=s programmatic activity involves developing and assessing new and emerging prevention methodologies and approaches in real-life settings; collecting, analyzing, and synthesizing prevention outcome knowledge, and monitoring national trends in substance abuse and emerging issues.

Cross-site studies are designed to test the efficacy of research-based and/or popular programs and to answer major questions in the prevention field, such as: AWhich are the most cost-effective prevention approaches for different populations?@ and AWhether to provide school-based or community-based interventions to all children or families as compared to more tailored and targeted interventions to high-risk youth and families?@ Cross-site studies link 8 to 14 teams of investigators into a Alearning community@ to share information on best practices, implementing prevention programs with fidelity, best evaluation instruments, and data analysis methods. Some of CSAP=s projects link the best known NIH researchers into these collaborative studies. All cross-site studies use a conceptual process to agree on the same core outcome and process measures to facilitate cross-site analyses by coordinating centers. The KDA programs help fill the gaps where culturally-adapted prevention strategies and relevant materials are needed for diverse populations in need of prevention services, such as children of drug abusers, immigrant youth, suicidal and depressed youth, adopted or foster care children, and youth suffering from HIV disease, physical and mental handicaps, aggressive, violent or conduct disordered behaviors, depression and other emotional disorders.

Combined, CSAP=s knowledge development programs form a strategic package that works to develop knowledge about prevention strategies effective across the life-span, with specific programs targeting early childhood, children and their families, adults, and the elderly.

A. Early Childhood

Starting Early Starting Smart (SESS) Cross Site Study.

Children growing up in poor families, especially those living in neighborhoods troubled by violence and substance abuse, suffer the most behavioral and health problems. Designed to address the needs of very young children (age zero to seven), the Starting Early Starting Smart program builds on research findings that early intervention and integrated services from a number of agencies are critically important to successful outcomes for very young children. This 12-site study is a public/private collaborative effort among SAMHSA=s three Centers, the Health Resources and Services Administration, the Administration for Children and Families, the National Institutes of Health, the Department of Education and The Casey Family Program. See GPRA plan for standard measures, program specific measures, and update information.

Having interviewed and enrolled families in both primary care and early childhood service settings, SESS projects are generating new empirical knowledge about the effectiveness of integrating substance abuse prevention, substance abuse treatment and mental health services for children ages zero to seven and their families/caregivers who experience risk factors for substance abuse or mental disorders.

Importantly, projects are measuring processes being used to provide integrated services in order to understand the role played by specific service designs in program success and are using a common research design and data collection methodologies. In particular, projects are measuring differences in child, family/caregiver and systems outcomes (e.g., child attachment/bonding, substance abuse and psychological functioning, access, utilization, school readiness) that can be linked to non-traditional primary care or early child care settings that integrate behavioral health services. The Casey Family Program has indicated interest in sustaining some of the successful projects in this program after Federal funding ends.

SESS supports GPRA Goal 1 (Bridge the gap between knowledge and practice). See the GPRA plan for the standard and program specific measures. This program is also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco.

Developmental Predictor Variables 10-Site Study

This applied research initiative is a multi-site study which looks at four individual and environmental indicators (risk and protective factors) for alcohol and other drug use. It takes prevention research beyond identifying what works to also determining the sequencing of when interventions are most effective. This first-of-its-kind study will help determine at what developmental stage the introduction of specific prevention interventions deter later behavioral disorders and substance abuse. See GPRA plan for standard measures, program specific measures, and update information

The program derives from NIH research identifying the importance of early and repeated interventions over the lifespan. It is anticipated that successfully changing this developmental path toward deviant behavior will lead to healthy social and emotional development and promote mental and emotional well-being.

Ten projects were funded for a three-year period to study four specified developmental stages-- children ages 3 -5, 6 -8, 9 -11 and 12 -14. The projects follow each age group for two years, and then link the cohorts together to capture the developmental range from 3- to 14-years of age. The program is generating consistent, statistically significant, positive outcomes, with all sites using the same core process and outcome instruments. As a result of interventions delivered in the Predictor Variables program, investigators in Utah, Georgia, North Carolina and Washington have reported decreases in family conflict, aggression, and conduct disorders, improved cooperation and academic performance, and decreases in substance use among their study populations.

This program supports GPRA Goal 1 (Bridge the gap between knowledge and practice). See the GPRA plan for the standard and program specific measures. This program is also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco.

B. Youth and Adolescents

Prevention Interventions/Field Studies

This program, initiated in FY 1999, supports field-initiated projects that test, replicate, or extend to other populations substance abuse prevention interventions. Projects replicated have demonstrated effects for preventing, delaying, or reducing alcohol, tobacco, or illicit drug use among vulnerable populations in previous rigorously controlled experimental studies. The program=s focus ensures maximum effectiveness potential for generalizability with many populations because tried models are adapted, with assistance as needed, and then applied under real world conditions. In this program, grantees will be able to refine, adapt, and implement effective research-based interventions for vulnerable populations in their local community settings and/or with diverse populations or conduct follow-up studies of research-based interventions that show significant positive effects to see how long these effects can be sustained over time. Interventions such as family mentoring/support, school violence/school climate change interventions, and life transitioning interventions, and vulnerable populations such as persons with physical or mental disabilities,

Native American and immigrant children, and persons living in rural areas are among the many possible focus areas of these programs.

This program supports GPRA Goal 1 (Bridge the gap between knowledge and practice). This program is also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco. Grants have not yet been funded for this new program therefore specific GPRA measures will be developed post award. Grantees will be expected to report on CSAP mission GPRA measures where feasible. Measures will also reflect progress towards achieving the goals of the GFA, specifically the extent to which the selected interventions and associated results prove sustainable, replicable and/or generalizable .

Alcohol and Youth

Extending efforts that address the impact of alcohol use and abuse by youth and adolescents, CSAP will also continue to support two research activities being conducted in collaboration with the National Institute on Alcohol Abuse and Alcoholism (NIAAA). First, a five year research grant program started in FY 1998 entitled *Effects of Alcohol Advertising on Underage Drinking* will continue to determine whether alcohol advertising affects the initiation of drinking among youth, and whether alcohol advertising affects their consumption patterns. Grantees are exploring both short- and long-term relationships among exposure to alcohol advertising, alcohol expectancies and other mediating variables, (e.g., personality or family norms), and actual consumption of alcohol among youth.

In a second collaborative effort, CSAP will continue to partner with NIAAA and the Department of Education in a five-year research grant program begun in FY 1999. This program, entitled *APrevention of Alcohol-Related Problems Among College Students@* seeks to identify, test, and/or develop effective interventions to prevent and reduce alcohol-related problems among college students and encourages three intervention approaches: (1) environmental interventions to change external contingencies that promote or inhibit college drinking; (2) individual-focused interventions that affect drinking behavior by influencing the knowledge, attitudes, and skills of the individual; and (3) multi-component interventions that include both approaches. CSAP is particularly interested in funding the assessment of environmental interventions.

This program supports GPRA Goal 1 (Bridge the gap between knowledge and practice). This program is also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco. CSAP, along with the Department of Education, is contributing resources to support this NIAAA program.

C. Families

Research evidence consistently shows that good parenting is a major factor in positive youth development and that programmatic technologies exist which have proven track records for improving parenting,

increasing family functioning, improving children=s outcomes, and preventing drug use and doing so at a relatively low cost. The programs implemented under this initiative are reinforcing and strengthening the role of parents in preventing substance abuse among youth. Included within this Initiative are several program efforts including:

Children of Substance-Abusing Parents (COSAP) Cross-Site Knowledge Development Study

Certain children are at increased risk for using tobacco, alcohol or illicit drugs because their parents abuse substances. Previous high-risk youth programs using the general population informed us that children of parents who currently abuse alcohol, tobacco and other illicit drugs are more vulnerable to using and abusing these substances themselves. At least 25% of the children of substance abusing parents will, themselves, become victims of substance abuse. These children of substance abusing parents (COSAPs) face significantly higher-than-average risk for early substance use, the development of dependence on substances, and a variety of physical and mental health problems. They are considered four times more likely than other youth to become alcohol- or drug-dependent. Addressing this issue, this knowledge development program, initiated in 1998, focuses on children of substance abusers who we know are at high risk for early onset, use and abuse of alcohol, tobacco and other illicit drugs.

The program focuses on three age groups of COSAPs -- 6-8, 9-11 and 12-14 year olds-- and their siblings whose parents are currently in or have attended substance abuse treatment programs. The programs are intended to determine the best prevention models and associated services for enhancing COSAPs= protective factors and minimizing their risk for developing substance abuse and/or other behavioral or emotional problems as a result of their parents= substance abuse. CSAP anticipates developing knowledge about effective and cost-effective practices and implementation strategies for prevention interventions for this population and about the impact that prevention interventions and associated services have on child substance abuse behaviors, parental substance-use behaviors, parenting skills, and parent-child commitment and bonding.

COSAP supports GPRA Goal 1 (Bridge the gap between knowledge and practice). This program is also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco. In addition to the GPRA mission measures, performance measures for this new program include:

Measure 1:Increase service receipt and dosage, such that 80% of test subjects will have received a uniform dose of
Measure 2:

For COSAPS, decrease by 5% from the FY 1999 baseline measures of the cognitive developmentally negative sequelae of their parents' condition by increasing academic performance and school attendance by at least 5% more in FY 2000 than the FY 1999 baseline measure.

Welfare Reform and Substance Abuse Prevention for Parenting Adolescents

In a similar vein, CSAP is addressing vulnerable adolescents who are parents of young children, who collectively face many critical, complex and pervasive problems that place them at high risk for substance abuse. Recent changes to the welfare laws that affect parenting teens= living arrangements and educational/training opportunities may lead to negative outcomes and increased risk for substance abuse. Strong association between teen parenting and childhood sexual and physical abuse and substance abuse may also result in some teens losing social supports and increasing their exposure to additional negative outcomes such as homelessness and HIV/AIDS.

CSAP=s Parenting Adolescents Program, initiated in FY 1998, will continue to build the knowledge base about the effects of welfare reform on parenting teens and measure the effects of preventive interventions tailored to this population. The program is helping parenting teens resist substance abuse, improve academic achievement and complete school, avoid repeat pregnancies, and improve their life- and parenting skills, as well as their health and well-being. It is anticipated that grantees will generate new empirical knowledge about services (individual or in combination) that are most effective in: reducing the dependency of adolescent parents on "Block Grants for Temporary Assistance for Needy Families" (TANF); reducing and preventing substance use and abuse; eliminating or reducing subsequent pregnancies, and increasing academic performance, parenting and life skills.

This program supports GPRA Goal 1 (Bridge the gap between knowledge and practice). This program is also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco. In addition to the CSAP mission measures, program GPRA measures include:

Measure 1: Increase service receipt and dosage, such that 80% of test subjects will have received a uniform dose of preventive interventions by FY 2001 as compared to the FY 1999 baseline.
Measure 2: Decrease substance use 10 % from the baseline by FY 2001.

Strengthening Families

Initiated in FY 1999, this two year effort is intended to determine cost effective methods for disseminating information and training on research-based, family-focused prevention strategies and models in order to extend the application of these demonstrated effective models to multiple communities across the country. Community agencies are being supported to determine the best parenting and family program that will address their local needs, trained to implement these programs with fidelity and to make the cultural modifications needed to be more effective, and assisted in evaluating their effectiveness in reducing drug abuse, child abuse and neglect, and children=s violent and delinquent behaviors. The information gleaned from this study will help CSAP to better translate the effective science-based models that work to practitioners and to thereby better bridge the gap from research to practice. As part of this program, at

least two communities in every State and Territory will be trained and funded to implement an effective parenting and family support program.

Public/Private Sector Workplace Models And Strategies for the Incorporation of Substance Abuse Prevention and Early Intervention Initiatives into Managed Care

Funded in FY 1997, this three year study is designed to assist CSAP in better understanding the nature and scope of promising managed care models for reducing the incidence and prevalence of substance abuse at the workplace, for employees and their families. The study is a collaborative effort between the public/private sector and CSAP.

It is important to understand the context of workplace-related substance abuse prevention within the health care system. The overwhelming majority of health care services delivered in the United States are provided through health plans funded by employers as a fringe benefit, not through publicly funded health care such as Medicaid/Medicare. The addition of substance abuse prevention, early identification and early intervention into private sector managed care and other health care plans across the nation is important to the Nation=s health, since more than 115 million employees are covered under such programs (and with all covered lives, approximately 200 million Americans, out of a United States population of approximately 265 million).

Ultimately, widespread adoption of these programs, in both the public and private sectors through non-legislative means, will be facilitated by information documenting the cost and cost-effectiveness of successful programs. This program will reach more than 25,000 employees and many more covered lives in 20 - 30 sites across the nation.

Preliminary information indicates substantial gains resulting from prevention efforts in the workplace. In a retrospective analysis of an insurance related industry, the addition of substance abuse prevention materials to workplace health promotion offerings has led to improved attitudes and behavior related to substance use. Additionally, workers who participated in health promotion/substance abuse prevention interventions were more likely to access health care for alcohol and other drugs and related mental health problems. Further, employee injury rates can be reduced, as was the case in a nationwide transportation workplace program where preliminary retrospective analysis found that, over a 12 year period, employee injury rates were reduced when a peer-to-peer substance abuse prevention/early intervention program was introduced.

This program supports GPRA Goal 1 (Bridge the gap between knowledge and practice). See both the SAMHSA and GPRA plans for the standard and program specific measures. This program is also in support of the ONDCP National Drug Control Strategy Goal 3:

D. Women

Women with Alcohol, Drug Abuse, and Mental Health Disorders Who Have Histories of Violence.

Research has clearly shown that existing health care systems are not designed, nor are they prepared, to adequately address the problem of co-occurring substance abuse and mental health disorders and violence among women. CSAP will continue as a collaborative partner in this cross-SAMHSA community-based study designed to develop new, more effective programs essential to caring for female victims of violence and for their children who also may be affected. This initiative is being conducted in two phases: first, to develop an integrated system of care with services intervention models and qualitative evaluations and second, full scale implementation of integrated strategies, services intervention models and outcome evaluations. The study is expected to generate valuable knowledge on the confluence of violence and co-occurring substance abuse and mental health disorders and assist local communities in developing an appropriate blend of services that will address trauma-related problems experienced by women who have experienced at least two treatment episodes within either substance abuse or mental health systems.

Violence Against Women is a new cross-cutting initiative that seeks to promote the improved coordination of services to women and their families affected by violence. CSAP will work with CSAT and CMHS to provide cross training for service providers from diverse backgrounds and communicate information regarding new service approaches and improving service delivery systems.

This program supports GPRA Goal 1 (Bridge the gap between knowledge and practice). This program is also in support of the ONDCP National Drug Control Strategy Goal 1. This cross-Agency program is currently developing its GPRA measures in conjunction with all participating entities. We anticipate that, at a minimum, CSAP GPRA measures will be used where feasible.

E. The Elderly

Aging, Mental Health and Substance Abuse in Primary Care Program.

Completing its focus on developing knowledge about effective prevention interventions across the life-span, CSAP will continue to partner with other SAMHSA Centers and HRSA in a collaborative effort designed to identify effective strategies for reaching the elderly population at risk for substance abuse. Substance abuse, particularly the combined use of alcohol and prescription drugs, goes largely undetected among adults over age 60. Psychosocial and health factors related to the aging process are the major contributors to alcohol and other drug use in older adults. In this program, grantees are seeking to determine the most effective models for delivering substance abuse prevention services for older adults within the framework of primary health care and how the location, type of provider, and type of health care financing affect the level of older adults**:** actual use of substance abuse services and their service outcomes.

This program supports GPRA Goal 1 (Bridge the gap between knowledge and practice). This program is also in support of the ONDCP National Drug Control Strategy Goal 3. See GPRA plan for standard and program specific measures.

F. Community Interventions

CSAP Community Coalitions Program.

Projects funded under CSAP's Community Coalitions program are now nearly complete but findings from these programs are still being collected and synthesized. Funded coalitions had to consist of two or more partnerships (each partnership having to be a multi-organizational entity to start with). This program sought to create public/private sector linkages in communities—among government, law enforcement, business, the faith community, health and social service providers, education, and the grassroots—and to encourage coordination and collaboration in communities= efforts to prevent and reduce substance abuse and its related consequences. The strategies implemented by these programs include: prevention education and training, alternative activities, information dissemination, environmental initiatives (social policy and media strategies), and community mobilization. This program is based on knowledge gained from the prior CSAP Community Partnership Program, whose evaluation results are summarized below.

This program supports GPRA Goal 1 (Bridge the gap between knowledge and practice). This program is also in support of the ONDCP National Drug Control Strategy Goal 1. See GPRA plan for standard and program specific measures.

Knowledge Development Accomplishments

Since 1987, CSAP has supported the testing of a wide array of interventions to prevent substance abuse. These comprehensive demonstration programs focused on six identified domains (individual, family, school, peer group, neighborhood/community and society/media). The knowledge gained from these and other research efforts forms the basis for CSAP=s Knowledge Development studies. These programs identify promising approaches, develop effective prevention strategies, evaluate innovative prevention methods, and monitor emerging issues and national trends. Examples of the positive outcome results for drug use and empirically-tested precursors of drug use found in CSAP grantee studies follow:

< Preliminary results from the **Developmental Predictor Variable 10-site Cross-site Study** are demonstrating that age appropriate strategies are successful when they target the particular risk factors associated with each developmental level. For example, parenting behavior and family cohesion in the intervention group significantly improved; children in the intervention group significantly reduced aggressive behavior and increased social competency; and school attendance rates increased to 90%.

- CSAP=s **Community Partnership Program Evaluation** documented lower drug use rates for particular populations in partnership communities vs. comparison communities. Of particular interest is the unexpected gender difference finding in the results -- effects on rates of drug use for males were much stronger than for females, highlighting the need for gender-specific interventions. This knowledge results from applying research to real life contexts which is then fed back in the research loop to examine possible causes and successful strategies. For example, as a group, partnership communities were associated with lower rates of substance abuse relative to matched comparison communities; adult past month alcohol use was significantly different between partnership and comparison communities; and male substance use rates were significantly lower relative to the comparison communities in 1) adult illicit drug use, 2) alcohol past month use, 3) 10th grade past month illicit drug use, and, 4) 8th grade illicit drug use and past month alcohol use. Female substance abuse rates did not show these significant differences. The number of prevention services and activities increased by 300% for partnership communities.

- CSAP=s **Replication Grantee Program Cross-site Evaluation** has determined that programs with higher dosage and better fidelity to program design/implementation are more effective. Jan Miller-Hyle=s *Dare To Be You* parent training program, for example, was culturally adapted by grantees in Colorado, California, and Utah for high risk Native American, African-American, Hispanic, Korean, Vietnamese, Samoan, and Tongan families of 3-5 year olds, showing significant improvements in protective factors such as improved family and parent/child relationships, parenting self-efficacy, democratic parenting style, decreased corporal punishment, children=s cooperation, and social skills.

2. **Promote the adoption of best practices -- Knowledge Application**

After field testing promising approaches in Knowledge Development programs, CSAP=s emphasis shifts to the synthesis and dissemination of the knowledge gained from these final study phases to the practical application of these strategies by States, communities and providers.

CSAP Knowledge Application (KA) programs are designed around a three-pronged approach to help substance abuse prevention practitioners and policy makers in States and communities systematically deliver and apply skills, techniques, models, and approaches to improve substance abuse prevention services. These efforts facilitate the synthesis and exchange of substance abuse prevention knowledge, technologies, and innovations among researchers, evaluators, practitioners, as well as laypersons, to enable successful adoption and use of effective approaches at national, State, and local levels. In the aggregate, CSAP=s knowledge application programs complete the research to practice continuum by synthesizing and translating scientific findings into useable knowledge, programs and packages, disseminating that knowledge widely, and helping States, communities and individuals to adopt and use it to meet local needs.

CSAP's three-pronged approach is designed as follows:

a. <u>Knowledge Application -- States, communities and local practitioners.</u>

All of the following programs are in support of GPRA Goal 2 (Promote the adoption of best practices). The knowledge application programs targeted to States, communities, local practitioners, and the general public are in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

CSAP=s *Prevention Enhancement Protocol System (PEPS)* and *National Center for the Advancement of Prevention - II (NCAP II)* are primary examples of programs that collect, synthesize and translate and disseminate research- and practice-based findings in useable form for application in communities. PEPS is a pioneering initiative that develops program and intervention guidelines for the field. Following established Arules of evidence@ for assessing practice and research findings and combining this evidence into prevention approaches, the PEPS initiative has published two guidelines: APreventing Tobacco Use Among Youth: Community-Based Approaches@ and APreventing Substance Abuse Among Children and Adolescents: Family Centered Approaches.@ Additional PEPS guidelines in the developmental pipeline include: AReducing Problems Related to Retail Alcohol Availability: Environmental Approaches,@ AMass Media Approaches to Substance Abuse Prevention,@ and ASchool-Based Approaches to Substance Abuse Prevention.@ CSAP=s High Risk Youth Database and National Register of Effective Programs also serve to collect and transfer information on effective substance abuse prevention methods and models gleaned or derived from CSAP Knowledge Development programs to the field.

NCAP II enables CSAP to develop, synthesize, update, adapt and disseminate state-of-the-art prevention knowledge about what works in prevention, for whom, and under what conditions. NCAP II centralizes, in one initiative, the synthesis of scientific and practice-based prevention knowledge and creates useful activities and products to support decision-making by Federal, State, and community substance abuse policy makers, planners, and practitioners. NCAP II enables CSAP to make available knowledge-based tools, principles and models useful for developing prevention plans, making resource allocation decisions, implementing appropriate and effective prevention programs, and satisfying increasing demands for public accountability for cost-effective prevention efforts.

And, in broadening the impact of prevention science, CSAP=s *Faculty Development Program (FDP),* which includes schools of medicine, social work, psychiatry, and public health and residency training programs in preventive medicine, is continuing to develop a cadre of health professionals with an expertise in teaching and advocating for substance abuse prevention. This program, through its penetration into schools of public health will significantly impact managed health care executives in the future. The interdisciplinary training that FDP fellows receive uniquely prepares them to provide the integrated health services necessary to meet the population based challenges facing the American public. The faculty fellows, via their mandatory community linkages, are developing a bi-directional relationship with their communities assuring that their academic institutions become an integral part of the community, thereby undergirding its infrastructure.

CSAP will also continue to provide technical assistance to the DOJ Office of Juvenile Justice and Delinquency Prevention as they administer, on behalf of ONDCP, the Drug-Free Communities Program. This program, initiated in FY 1998, supports community efforts to strengthen collaboration among communities, enhance intergovernmental cooperation, increase citizen participation, and disseminate to communities state-of-the-art information about proven, effective prevention initiatives and strategies.

b. Knowledge Application -- Workplaces

This program supports GPRA Goal 2 (Promote the adoption of best practices). The knowledge application programs targeted to the workplace are in support of the ONDCP National Drug Control Strategy Goal 3, Objective 3 and Objective 4: Promotion of drug-free workplace programs

CSAP has two major knowledge application efforts targeted toward applying substance abuse prevention knowledge within the workplace. CSAP will continue to operate the *Federal Drug Free Workplace (DFWP)* and *National Laboratory Certification (NLCP) Programs.* DFWP covers 1.8 million Federal employees in approximately 120 agencies. The program aims to reduce adult substance abuse demand in the Federal service. Comprehensive in nature, the program requires: a clear organizational policy of non-use and consequences of use; employee education about the dangers of drug use and the organizational policy; supervisor training about the organizational policy and their responsibilities regarding employee substance abuse; access to professional referrals for counseling and treatment as appropriate for each case; and drug testing, based on accuracy, reliability and correct and fair interpretation of results. The NLCP promulgates scientific and technical guidelines for Federal employee drug testing programs. It is designed to certify drug testing laboratories, develop a system and provide guidance to DHHS self-sustaining drug testing programs. NLCP certifies 72 laboratories in the United States to conduct workplace forensic drug testing, having direct impact on over 25 million workers nationally.
NLCP has also been the Federal focal point for developing and implementing non-military, Federal workplace drug testing related technical, administrative and quality assurance programs; NLCP certified laboratories impact about 8 million Federal and federally regulated industry employees annually . The DHHS/NLCP standards are considered the Agold standard@ for drug-free workplace programs nationally, and are being incorporated into the drug testing programs in Canada and Mexico. In addition, the CSAP Workplace Helpline provides individualized technical assistance to businesses, industries and unions in the development and implementation of comprehensive drug-free workplace programs.

c: Knowledge Application - Public at Large

CSAP supports several major knowledge dissemination and application efforts whose primary focus is reaching and addressing the general public.

< As part of the National Family Strengthening Initiative, CSAP=s *Parenting IS Prevention* Program is strengthening existing anti-drug programs directed at parents and developing a drug focus for various

parent groups that do not currently have a major drug focus by providing training, technical assistance and resources for parents in initiating drug prevention programs for youth. Under this component of the Initiative, a parent training manual has been developed and ongoing meetings designed to mobilize parents at the community level are being conducted. CSAP will continue to assist communities in adopting science-based effective family strengthening programs which involve parents and other care givers, enhance youth resiliency, and reduce family psychosocial risk factors and that are expected to lead to reductions in youth substance abuse.

< *Public Education Campaigns*. Public education at the national level provides clear and consistent messages about substance abuse and its consequences. It also helps mobilize communities and people into action. CSAP=s three major national public education campaigns are developed for specific target audiences. CSAP synthesizes science-based prevention research and uses social marketing approaches in developing these campaigns.

- The *Reality Check* Campaign is designed to help communities prevent new use and reduce existing use of marijuana among 9- to 14- year olds. Since its launch in 1996, the Campaign has been implemented by community groups and organizations at both State and local levels using the *Reality Check* Community Kit.

- The *Girl Power!* Campaign is designed to stem the erosion of self-confidence, motivation, and opportunity during the pivotal age of 9-14. It is during this period that girls become more vulnerable to negative outside influences, especially drug use. The campaign has reached over 85 million girls and adults. A new campaign targeting Hispanic girls modeled after *Girl Power!* will deliver tailored and culturally-relevant Ano use@ messages about alcohol, tobacco and illicit drugs tailored their needs

- Through collaborations with over 276 organizations and 59 national endorsers, including the Girl Scouts of the U.S.A., The *Your Time - Their Future* multimedia campaign urges adults to become actively involved in working with children, ages 7 to 14, to develop healthy and useful skills and interests. It encourages adults to volunteer and devote more quality time with youth in need of guidance and mentoring to prevent drug use. It is based on research showing that involvement in skill-building and structured activities will help youth develop the self competence needed to protect them from using drugs. Since its launch in November l998, it has reached over one million people.

- CSAP=s *Alcohol: We=re Not Buying It* Campaign will continue to target alcohol use among underage youth.

The Public Education program supports GPRA Goal 2 (Promote the adoption of best practices). The knowledge application programs targeted to States, communities, local practitioners, and the general public are in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth

to reject illegal drugs as well as alcohol and tobacco. See the SAMHSA and GPRA plans for standard and program specific measures.

< CSAP=s *National Clearinghouse for Alcohol and Drug Information* is the hub of the Federal Government's effort to collect and communicate information about effective prevention, intervention, and treatment policies, programs, and strategies as well as an important link to scientific research on substance abuse. In so doing, NCADI uses multi-level communications approaches to reach diverse audiences across the country. For more than ten years, NCADI has served as the nation=s single point of entry for comprehensive, customer-oriented information services regarding substance abuse prevention, intervention, and treatment information. Demand for accurate, relevant, and concise information about alcohol and illicit drugs has grown dramatically since NCADI=s inception in 1987. In October 1998, NCADI, the largest Federal health information clearinghouse, expanded call center operations to 24 hours a day, 7 days a week to respond to demand generated by the ONDCP National Youth Anti-drug Media campaign as well as various CSAP and HHS public education campaigns. NCADI has also taken on responsibility for CSAT=s National Treatment Helpline.

NCADI supports GPRA Goal 2 (Promote the adoption of best practices). The knowledge application programs targeted to States, communities, local practitioners, and the general public are in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco. See GPRA plan for standard and program specific measures.

Knowledge Application Accomplishments

CSAP's **National Center for the Advancement of Prevention (NCAP)** is the chief program effort that identifies, synthesizes, and translates research findings into user-friendly products ready for integration into practice. NCAP has performed critical literature reviews, including A*Environmental Strategies for Substance Abuse Prevention: Analysis of the Effectiveness of Policies to Reduce Alcohol, Tobacco, and Illicit Drug Problems*, several Implementation Guides such as one on *The Role of Education in Substance Abuse Prevention*, Technical Reports such as *A Review of Alternative Activities and Alternative Programs in Youth Oriented Prevention*, and a series of large scale Meta-Analyses, each focusing on a specific topic area relevant to substance use prevention, including, for example, *Correlates of Marijuana Use Among Youth* and *Meta-Analysis of the Effectiveness of School-Based Programs.*

The **Prevention Enhancement Protocol System (PEPS)** is a CSAP initiative to develop evidence-based program planning and intervention guidelines for the field of substance abuse prevention. To date, two PEPS guides have been published: Reducing Tobacco Use Among Youth: Community-Based Approaches and Reducing Substance Abuse and Children and Adolescents: family-based Approaches. These PEPS have been very well received in the field and among CSAP=s prevention allies nationwide. Reducing Tobacco Use Among Youth has been used extensively by the Centers for Disease Control and Prevention as part of their

tobacco use prevention activities for adolescents. The Community Anti-Drug Coalitions of America (CADCA) plans to distribute the guides to their community coalition members; and the National Library of Medicine will include PEPS on its website.

The SAMHSA/CSAP **National Clearinghouse for Alcohol and Drug Information (NCADI)** responded to approximately 230,000 requests in FY 1998 and distributed over 22 million free or at-cost Federal publications and products. In its first two weeks, the ONDCP National Youth Anti-Drug Media Campaign resulted in a 121 percent increase in caller volume as a result of the media advertising in 75 media markets. Compared to the same timeframe in July last year, the increase in NCADI caller volume is 220 percent. This increased level of caller volume is expected to continue to escalate dramatically as the ONDCP media campaign expands. Demographic information indicates that 45 percent of the callers had seen the 1-800 NCADI number in a newspaper ad. The second largest exposure (35 percent) to the 1-800 NCADI number was from TV commercials. Callers identified themselves as from the Ageneral public@ in 55 percent of contacts. Prevention was the top subject of interest for 69 percent of the callers.

CSAP=s **Reality Check** campaign focuses on preventing marijuana use by 9- to 14-year old youth. Its outreach thus far has included 1,648 articles in print media with a combined circulation of 40 million people; television news stories broadcast by all four major networks; other cable and local programs in major markets; a total of 189 radio stations, with an estimated audience of more than 5 million listeners, have broadcast a particular story 861 times; from January through July, 1998, there have been 176,786 web site hits.

Action at the community level as a result of the heightened interest and awareness has been facilitated by the development and distribution of user friendly materials such as a kit complete with examples and camera-ready materials, and a Guide for Parents and Caretakers on talking to youth about drugs. The campaign was adopted by the National Parent Teachers Association and thousands of Guides for Keeping Youth Drug-free (a Reality Check product) were distributed throughout its national chapters. Community-based activities growing out of Reality Check have been undertaken in Georgia, Kentucky, Michigan, and West Virginia. In New Jersey, a project through the Governors= Council on Alcohol and Drug Abuse, the Partnership for A Drug Free New Jersey, DARE New Jersey, and the Department of Education was undertaken to focus specifically on reaching parents and caregivers of fifth graders in the state to stress the need for their involvement in talking about the marijuana problem in their homes, schools, and community settings. Thousands of CSAP=s Guide to Keeping Youth Drug-Free were requested and made available to support this effort.

Since its launch in 1996, the **Girl Power!** campaign is becoming more visible and more entrenched into the local communities. As of November 1998 Girl Power! reached over 8.7 million people through messages, web site visits, and media circulation . There are 567,0977 average monthly visits to the web site with each visit lasting approximately 7 minutes and 30 seconds. NCADI receives approximately 3,500 Girl Power! related phone calls per month. An average of three thousand calls a month are received by SAMHSA=s

National Clearinghouse for Alcohol and Drug Information (NCADI) for Girl Power! information. This number is down from 8,000 a month since a Girl Power! order form was included within the Girl Power! web site.

There is clear evidence of its impact on developing community public/private linkages. One example is Girl Power! and the Suffolk County Organization for the Promotion of Education (SCOPE). This Long Island organization is writing a grant for corporate funding to reach elementary and middle school at-risk girls with healthy prevention messages and teach them skill-building techniques for resilience and empowerment. They plan to make this a pilot program, evaluate the results, and disseminate the information through their connection with The National School Study Council, in the hopes that their program will become a Girl Power! model to be used across the country. SCOPE has been serving communities and school throughout Long Island, NY for the past 35 years and is national recognized for the excellence of their education program offerings.

Girl Power! continues to receive recognition through numerous web site awards. Secretary Shalala received a 1998 Sara Lee Foundation Award in part for her Girl Power! Initiative, and our products have received awards.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995.....	$238,234,000	---
1996.....	91,999,000	---
1997.....	155,869,000	---
1998.....	84,321,000	---
1999.....	78,717,000	---

Rationale for the Budget Request

The budget request includes a total of $52,717,000 for CSAP's KDA portfolio. The available amount is approximately 34% below the FY 1999 funding level and is sufficient to support most programs at a reduced level. No new programs will be supported.

The FY 2000 budget reflects CSAP=s commitment in moving the substance abuse prevention field forward into the 21st century. Its program agenda and portfolio continue to build on the strengths of our current programs and progress in identifying and implementing best practices and addressing critical prevention capacity needs of States and communities.

C. CENTER FOR SUBSTANCE ABUSE PREVENTION
2. Targeted Capacity Expansion

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$66,679,000	$78,283,000	$78,283,000	---

2000 Authorization
PHSA Section 501..... Indefinite

GPRA Goal 3 -- Assure Services Availability/ Meet Targeted Needs
GPRA Goal 2 -- Promote the Adoption of Best Practices

Purpose and Method of Operation

CSAP=s Targeted Capacity Expansion (TCE) program is designed to address the specific and immediate prevention service capacity needs within the States and communities. As such, TCE programs help States and communities address gaps in prevention services which often cannot be addressed via the block grant funding process. With a primary focus on improving prevention service capacity and fostering the use of current Abest practices@ in actual service systems, these programs assure coordination and consistency in services provided and enable the collection of client outcome data for use in program planning and monitoring accountability.

All of the Targeted Capacity Programs are in support of GPRA Goal 3 (Assure services availability/Meet targeted needs) and GPRA Goal 2 (Promote the adoption of best practices). The TCE initiatives discussed below are also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco.

CSAP=s Targeted Capacity Expansion portfolio is comprised of the following major efforts:

1. <u>Targeted Prevention Capacity Program -- State Incentive Grants</u> (GPRA Goal 3)

CSAP's flagship Targeted Prevention Capacity Program effort is its State Incentive Grant (SIG) program, which uses a two pronged approach:

a) States utilize 85%, or approximately $2.5 million, of each SIG grant funds to implement best prevention practices that address the immediate and critical prevention service capacity that is not, or has not been met

via the traditional SAPT Block Grant funding stream. Most frequently the capacity needs occur in under-served populations and minority groups--including rural communities (e.g., in Kansas, Montana, Kentucky, and New Hampshire), as well as in American Indian and Alaskan Native jurisdictions (e.g., in Minnesota, Oregon, Washington, Arizona and Alaska).

b) Utilize 15% of the funds by the State Governors to develop a comprehensive State prevention plan that utilizes all Federal and State funding streams for prevention in providing coordinated and integrated prevention services across the State. In this manner, States not only address the unmet, often critical, needs of their communities but also improve the availability and accessibility of both new and existing substance abuse prevention services. Implementation of the SIG program substantially shortens the amount of time that it would have taken States to reach this level of Statewide coordination and collaboration to prevent substance abuse.

As the cornerstone of Secretary Shalala=s Youth Substance Abuse Prevention Initiative (YSAPI), the SIG program provides a unique opportunity for CSAP to work collaboratively with Governors and single state alcohol and drug abuse agencies to develop revitalized Statewide substance abuse prevention strategic plans, and to encourage and stimulate the identification, leveraging and/or redirection of funding for statewide substance abuse prevention. The bottom line impact of interest for the SIG projects is the reduction of alcohol, tobacco and illicit drug use in the target populations of the local sub-recipient communities. Many of the individual SIG grantees have other long-term, health-related outcomes of interest: reductions in juvenile delinquency, teen pregnancy, violent behavior, etc; however, they typically have several outcomes in common: alcohol use; tobacco (smoking) use; marijuana use; and other illicit drug use. In general, measures of actual use of each of the substances listed above included four primary indicators: lifetime use, annual use, 30-day use, and age of first use. Finally, the importance of evaluation in this far-reaching CSAP initiative is being emphasized at all levels.

Targeted Capacity Programs are in support of GPRA Goal 3 (Assure services availability/Meet targeted needs) and GPRA Goal 2 (Promote the adoption of best practices). GPRA plans for the standard and program specific measures. The TCE initiatives are also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco.

2. <u>Targeted Capacity Enhancement -- Centers for the Application of Prevention Technologies (CAPT)</u> (GPRA Goal 2)

CSAP=s National CAPT Program is the major mechanism used to provide support to CSAP=s State Incentive Grant (SIG) program. The fundamental mission of CSAP=s national CAPT Program is to promote the adoption of best practices in meeting the expanded and targeted capacity needs within States. The existing body of substance abuse prevention knowledge and experience at the Federal/national, State, and local levels provides clear and convincing research-based evidence that prevention works. However, much

of that evidence has not been brought to bear on practice in States and communities across America. The process of transferring proven research to daily application involves packaging knowledge into practical, user-friendly formats, which are culturally appropriate and sensitive to State and community needs, and then facilitating its adoption in the field. The CAPTs provide skill development and capacity building services that are targeted to SAMHSA/CSAP=s State Incentive Grant program grantees as well as other States and their communities. Areas (all related to substance abuse prevention) that are addressed by the national CAPT program include: assessing prevention materials/media; cultural competence; evaluation and research; identifying science-based programs; organizational development; prevention fundamentals; prevention in a specific setting (e.g., managed care organizations, workplace, correctional facilities); risk and protective factors; and technology (e.g., teleconferencing, Internet).

Organized according to the National Prevention Network=s geographic regions, five organizations were selected to serve as the regional CAPTs beginning in FY 1998. In FY 1999, a sixth CAPT, the Border CAPT, was awarded to serve the unique substance abuse prevention needs of the U.S.-Mexico border area. Each CAPT grantee brings a long and successful history working in the prevention field with diverse expertise in skills development and training, publishing, conferencing, personalized technical assistance to Single State Agencies and other entities, electronic media, community coalition-building, social marketing, evaluation, and grassroots mobilization.

The national CAPT program is expected to achieve increased accessibility to proven substance abuse prevention strategies; expanded State and local capacity in the substance abuse prevention knowledge application process; increased access to and use of electronic methods in the region; and established regional capacity for ongoing training and technical assistance. The national CAPT program also expects to identify the most effective delivery methods for helping communities adopt and sustain the use of research-based prevention programs, practices, and policies and the configurations of skill development and capacity-building activities that produce the greatest systems change.

In summary, the national CAPT program is moving the knowledge and information 'off the shelf' or 'off the page' and into practice so that State Incentive Grantees, their subrecipients, and other States get the benefit of substance abuse prevention research in efficient, direct, and user-friendly ways. Transferring proven research and getting it used at the State and community levels is an ongoing process of turning information into practical procedures that are put into practice in the field.

Targeted Capacity Programs are in support of GPRA Goal 3 (Assure services availability/Meet targeted needs) and GPRA Goal 2 (Promote the adoption of best practices). GPRA plans for the standard and program specific measures. The TCE initiatives are also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco

3. Targeted Prevention Capacity -- Substance Abuse Prevention and HIV/AIDS

Prevention for Youth and Women of Color (GPRA Goal 3)

This effort, initiated in FY 1999, responds to the pressing Astate of emergency@ that exists with respect to the extent and impact of HIV/AIDS on the African American community as highlighted by members of the Congressional Black Caucus (CBC). The overwhelming majority of AIDS cases among African American women and children is directly or indirectly attributable to alcohol or illicit drug use. The CBC has characterized the burden of HIV/AIDS on racial and ethnic minorities as a severe and ongoing crisis which requires both immediate measures and a long term commitment to resolve. The Substance Abuse Prevention and HIV/AIDS Prevention Initiative for Youth and Women of Color focuses on providing substance abuse prevention and HIV prevention services to African American youth and women of color, with a particular emphasis on building capacity, through training and technical assistance, in those communities with the highest incidence rates.

A major component of this initiative is a Substance Abuse/HIV Prevention Targeted Capacity Expansion program which provides funds to community-based organizations, Historical Black Colleges and Universities, Hispanic Colleges and Universities, Faith communities, and other coalitions and/or partnerships for the purpose of strengthening the integration of substance abuse prevention and HIV prevention services at the local level and increasing the provision of integrated services to African American youth and women of color. The HIV/AIDS initiatives will also work with CSAP=s Centers for the Application of Prevention Technologies (CAPTs) to enable them to integrate HIV prevention into their substance abuse prevention materials and curricula and to help build capacity within the CAPTs to provide training and technical assistance to community based organizations and other providers in those communities devastated by HIV disease. Finally, the HIV/AIDS initiative will partner with national organizations to undertake several key roles, including accessing and retaining minority youth and women in prevention programs, providing training and technical assistance to local affiliates for the prevention of substance abuse and ensuring the applicability and feasibility of proposed community programs, coordinating and convening the component service and training programs of the initiative, and providing technical assistance to the CAPTs in the incorporation of HIV prevention within substance abuse prevention materials and curricula available from them.

Targeted Capacity Programs are in support of GPRA Goal 3 (Assure services availability/Meet targeted needs) and GPRA Goal 2 (Promote the adoption of best practices). The TCE initiatives are also in support of the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco. This TCE component is in the process of developing its GPRA performance measures. Where feasible, CSAP GPRA mission measures will be used.

Taken together, CSAP=s TCE portfolio represents a comprehensive effort to improve the quality and availability of effective research-based prevention services at the point of services delivery. This is occurring through the implementation, at the community-level, of science-based prevention programs that are part of integrated, comprehensive, state-wide prevention strategies and systems. This initial investment in the reduction of duplication, overlap and fragmentation and, at in the scientific enhancement of applied

prevention interventions, will yield significant cost savings at the community, State, and national levels over the long term.

Targeted Capacity Enhancement Accomplishments

1. State Incentive Grants -- By FY 1999, CSAP will have awarded a total of 21 Targeted Prevention Capacity, or SIG, grants. Already, dramatic progress has been achieved, and outcomes can be reported:

- Governors of the States with SIG awards have formed prevention councils and state-wide advisory committees appointing State legislators, government officials, community leaders, and corporate executives to advise them on allocating prevention dollars. Some have initiated media roll-outs, held press briefings and issued Executive Orders, all of which are promoting the merits of this critical capacity expansion and systems building program. *In Vermont, for example, Governor Dean convened a town meeting on adolescent substance abuse in December 1998 that drew more than 450 community people. Kansas Governor Graves has formed a new Kansas Prevention Council.*

- The first five States to have been awarded a SIG award have already successfully awarded 137 subrecipient community-based prevention grants for a total of close to $11.2 million. *As part of this funding, Oregon is providing $2.4 million to 36 counties and approximately 8 Federally recognized Native American tribal governments. In addition, Kansas has issued 31 community grants; Illinois, 28; Vermont, 23; and Kentucky, 11.* CSAP anticipates that more than 350 additional communities will be funded from the 16 SIG grants awarded in FY 1998 and FY 1999.

- The first five State awardees have also begun to identify, leverage and redirect funds for community-based substance abuse prevention efforts. States are making significant contributions of State money, related resources, in-kind support and staff to these grants. In particular, Governors= offices are supporting the grant program with evaluation expertise, State and community data collection efforts, community training, and technical assistance teams. *For example, Kentucky alone has leveraged an additional $1.1 million in funds--and it plans to award an additional 10-12 subrecipient grants by the end of the State=s fiscal year. In Oregon, the collaboration between the State Incentive Project and the Governor=s Juvenile Crime Prevention Project expects to leverage approximately $30 million.*

- As a result of the SIG program=s emphasis on collaboration, more States are beginning to think of substance abuse prevention from a broader, systems standpoint. *For example, in addition to Oregon=s collaboration with juvenile justice, Illinois has not only looked at the various funding streams coming into the State but has begun to build relationships with the various agencies from which these monies would be redirected. From this vantage point, State agencies in Illinois now have a closer working relationship, have built new levels of trust and have a broader, systems perspective.*

- Technical assistance to the community grantees also illustrates SIG States= commitment to ensuring the high quality of local prevention efforts. *For example, Vermont convened an orientation for its grantees to help them begin planning for implementation, refine their evaluation plans, and learn more about model programs and strategies. Kentucky held a training for its 11 grantees designed to refine their logic model for effective evaluation. Kansas= 13 Regional Prevention Centers will provide training and technical assistance to its subrecipient awardees.*

- Working closely with CSAP, the first five SIG states recognize the importance of accountability and evaluation. By consensus, they have developed a comprehensive evaluation framework, identified common measures and selected standardized instruments to be used across sites. Analyses of these cross-site data will add value to local sub-recipient communities as they gauge their own success and strive to modify programs and strategies to reduce substance abuse and related behaviors in their communities.

2. Centers for the Application of Prevention Technology (CAPTs): The five regional and one border CAPT have been making steady progress and have been well received by client States and communities. For example:

- Each of the first five CAPTs has established a regional advisory body to reinforce existing relationships and initiate new ones, building the capacity of each of its State members and the overall region.

- CAPTs are educating, informing and influencing the States through regional Web sites, workshops, and newsletters.

- CAPTs are developing materials, such as the Western CAPT=s ADeveloping Healthy Communities: A Risk and Protective Factor Approach to Preventing Alcohol and Other Drug Abuse,@ the Central CAPT=s APrevention and the Internet@ booklet, and Southeast CAPT=s APuerto Rico Prevention Directory.@

- The newest CSAP CAPT, at the Mexican Border, tailors materials and assistance to meet the unique needs of communities in the four States that share a common border with Mexico; this CAPT is coordinating skills development and technical assistance delivery with the Southwest and Western CAPTs.

- The Department of Education has supplemented CAPTs to deliver substance abuse prevention knowledge application efforts to States for implementation in schools.

- CAPTs, at the request of ONDCP, delivered training and technical assistance to the Office of Juvenile Justice and Delinquency Prevention=s first round of Drug-Free Communities Act grantees.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995	---	---
1996	---	---
1997	---	---
1998	$6,679,000	---
1999	78,283,000	---

Rationale for the Budget Request

The FY 2000 budget request provides a total of $78.3 million for CSAP=s Targeted Capacity Expansion portfolio. This funding level will provide support for all ongoing activities within the SIG, CAPT, and HIV/AIDS initiatives. Also included within the request are funds to support approximately 4 new State Incentive Grant awards. There are no funds requested to support any new CAPT or HIV/AIDS efforts.

C. CENTER FOR SUBSTANCE ABUSE PREVENTION
3. High-Risk Youth

Authorizing legislation - Section 501 of the Public Health Service Act

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$6,000,000	$7,000,000	$7,000,000	---

2000 Authorization
PHSA Section 501..... Indefinite

GPRA Goal 1 -- Bridge the gap between knowledge and practice

Purpose and Method of Operation

Since 1987, CSAP has supported the testing of a wide variety of interventions to prevent substance abuse among children and youth. These demonstrations have been comprehensive and have focused on the major domains--individual, family, school, peers, community -- which impact the life of a child. Based on knowledge gained from these and other research efforts, it has been found that intervening in a child=s developmental trajectory during certain vulnerable stages, to improve family functioning, school performance, and enhance life management skills, will ultimately decrease the likelihood of substance abuse. As a result, CSAP initiated a new program in FY 1998 to target high-risk youth, in particular, those youth who are at high risk for becoming substance abusers and/or involved in the criminal justice system. These youth are disconnected and alienated from the institutions and norms of mainstream society and are more likely to associate with peers that share this attitude, and to develop a set of attitudes and practices that either conflict with those of the mainstream or simply reflect a limited sense of future. Family dysfunction adds to this alienation. Alienated youth with few family and community supports are considerably more at risk for substance abuse and for becoming involved in risky and delinquent behaviors. Because of these factors, CSAP=s Project Youth Connect seeks to address these issues and to intervene with these youth while they are at a period in their lives when positive influences can still have an effect.

CSAP's Project Youth Connect supports GPRA Goal 1 (Bridge the gap between knowledge and practice). See both the SAMHSA and CSAP GPRA plans for the standard and program specific measures. The program also supports the ONDCP National Drug Control Strategy Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

Project Youth Connect is a knowledge development program designed to identify best practices in prevention or reducing substance abuse or delaying its onset in youth (9-15 years old) by improving: school bonding and academic performance; family functioning and overall life management skills. Youth in this age group are known to be vulnerable to environmental influences leading to substance abuse. The program uses two intervention strategies: 1) Youth only model where interventions include academic support, tutorial assistance, individual/group counseling, conflict resolution, problem solving, peer resistance behavior, violence prevention activities, substance abuse prevention, alternative/recreational activities, and community service activities, and 2) Youth/Family model which includes the interventions from the youth only models as well as a family component which includes parent effectiveness training, parent support groups, family bonding activities (picnics, family outings), support to parents in conducting school conferences, and support to other siblings in the family.

CSAP is evaluating the effectiveness of mentoring interventions in diverse programs that not only utilize community volunteers, but also employ health and human service professionals to work closely with the mentees, their families/caregivers and school personnel. CSAP is also be evaluating whether mentoring interventions alone or those in combinations with other interventions and services for both the youth and families/caregivers are the most effective in reducing substance abuse. They will also examine their effectiveness in reducing family and school violence, and improving community/school environments.

The Project Youth Connect Coordinating Center plans to have the survey instruments translated into Spanish for youth and their families who have English as their second language. Pending availability of expertise and financial resources, translation services will also be provided for those study sites serving first generation Asian American families. These translated instruments could prove to be useful to other researchers conducting national surveys. Some of the items in the instruments are from national survey protocols i.e. National Youth Survey (NYS), Causes and Correlates Family Attachment measures; Individual Protective Factors Index (IPFI).

Project Youth Connect Accomplishments

This science-based program is only a few months old. Thus far,

- In September 1998, CSAP funded 12 study sites and 1 coordinating center to implement this Knowledge Development Program. Three additional study sites were funded October, 1998. Examples of programs funded to date include:

  - a Philadelphia, PA, program which targets 120 low income African American middle school youth who have been bystanders to serious violence in their home, school, or community, and/or who may have been directly affected by violence;

- a program in Northern Colorado which is working with Hispanics, Mexican Americans, and European Americans ages 11-14 in two middle schools to improve academic performance, school bonding and life management skills among high risk youth;

- a program in St. Louis, MO., which is working with sixth graders from severely distressed neighborhoods in the city; and

- a program that is working with high-risk Chinese and Vietnamese immigrant youth from primarily low-income families with limited English proficiencies from areas around and within Los Angeles, CA.

! A conceptual framework for conducting the cross-site coordination of instrumentation, key indicators for data collection and documentation of success are currently being developed

Funding levels for the past five years were as follows:

	Funding	FTE
1995.....	---	---
1996.....	---	---
1997.....	---	---
1998.....	$6,000,000	---
1999.....	$7,000,000	---

Rationale for the Budget Request

The FY 2000 budget request provides a total of $7,000,000 million for CSAP's Project Youth Connect. This level will provide full funding support for the 15 study sites and one coordinating center awarded in FY 1998 and FY 1999. No new awards will be made.

C. CENTER FOR SUBSTANCE ABUSE PREVENTION
4. Substance Abuse Prevention and Treatment Block Grant (SAPTBG)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$248,920,000	$301,150,000	$306,850,000	+$5,700,000

2000 Authorization
PHSA Section 501..... Expired

GPRA Goal 3 -- Assure services availability/meet targeted needs

Purpose and Method of Operation

CSAP administers the primary prevention component of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) as it applies to 60 States, jurisdictions, and one Indian Tribe. The Block Grant 20% Prevention Setaside Program is one of the largest substance abuse prevention programs funded by the Federal Government. Twenty percent of the SAPTBG funds allocated to States according to legislative formula must be spent on substance abuse primary prevention services as outlined in Block Grant legislation. States vary widely in the extensiveness and scope of their prevention services. While some depend entirely on the 20% set-aside to support their activities, others use these funds to fill gaps and enhance existing programs: impact. The legislation is intended to have each state: 1) commit an absolute minimum of federal dollars to prevention, and 2) develop and sustain a Acomprehensive primary prevention program. Six strategies are mandated and include: information dissemination; education; community mobilization; alternatives; environmental change; and problem identification and referral.

The SAPTBG supports GPRA Goal 3 (Assure services availability/meet targeted needs.) See both the SAMHSA and CSAP GPRA plan for the standard and program specific measures. The SAPTBG also supports Goal 1 of the ONDCP National Drug Control Strategy: Educate and enable America's youth to reject illegal drugs as well as the use of alcohol and tobacco.

SAPTBG Accomplishments

Many States are dependent upon the Substance Abuse Prevention and Treatment (SAPT) Block Grant for funding of their State-wide prevention systems. Specific examples of the outcome from States use of these funds are as follows:

- The Colorado Alcohol and Drug Abuse Division (ADAD) spent approximately $3.5 million, combined with other resources, to support a range of alcohol, tobacco, and other drug prevention services to groups at risk. Prevention programs were encouraged to impact on multiple levels of social structures such as individuals, families, groups, institutions, and communities. Programs conducted in schools, communities, and the workplace have been shown to have resulted in the following changes: increased awareness of substance abuse problems; the use of positive approaches to prevention services; enhancement of providers= prevention skills; development of curricula, education and training materials. Colorado has adopted CSAP=s MDS software and is working with CSAP to enhance and expand its ability.

- Nevada, through the Bureau of Alcohol and Drug Abuse, funds 86 primary prevention programs addressing such risk factors as academic failure, cultural isolation, family management, gang activity, school dropout, and youth violence. Funded activities include the provision of a statewide alcohol, tobacco, and other drug abuse prevention information dissemination clearinghouse; the support of forty-one prevention education projects ranging from preschool targeted activities to numerous parenting projects targeting parents in challenging environments: the funding of fourteen community grants whose purpose is to provide alternatives to drug use and gang involvement; the identification of problems through the funding of six sites targeting populations at risk of substance abuse; the provision of grants to two communities to enhance/promote community organization in an effort to address substance abuse issues; and, the provision of funds to focus on addressing the sale of tobacco products to youth.

- States have progressed in their ability to comply with the Synar Amendment. Enacted in 1992, it seeks to reduce the sale of tobacco products to minors. In the last year, the authorities responsible for requirement enforcement and CSAP have made significant progress in developing enforcement infrastructures for this explicit purpose. Of the 51 such authorities (50 States and the District of Columbia), all have laws prohibiting the sale or distribution of tobacco to minors, and they are enforcing those laws. The median noncompliance rate of sales to minors as reported by the States in 1998 was 24.4 percent. This is a significant reduction from the median rate of 40 percent reported in 1997 and pre-1997 studies that found noncompliance rates ranging from 60 to 90 percent. Twelve States reported 1998 noncompliance rates of 20 percent or less. Three States reported noncompliance rates below 10 percent. All States have plans in place to ensure that their noncompliance rate is 20 percent or less by FY 2002. CSAP provided technical assistance (TA) to forty (40) States to support the implementation of programs and strategies that help prevent youth access to tobacco products. Most TA focused on helping States develop sound sampling designs to accurately assess their non-compliance rates.

In addition, a total of five percent of the Block Grant annual appropriation is required to be set-aside for Federal data collection, evaluation of programs supported by the Block Grant, and technical assistance. Of this five percent, 20% is available for prevention. Set-aside funds are used to conduct and utilize data from needs-assessment studies; to improve program planning, development, and services delivery; to provide on-site technical assistance, and other services to enable State agencies maximize the effectiveness of their

investment in prevention. A complete discussion of the use and accomplishments of the activities supported by CSAP utilizing the five percent set-aside is included in Section E.

Funding levels for the 20% prevention set aside for the past five years were as follows:

	Funding	FTE
1995	$246,821,000	10
1996	$246,821,000	10
1997	$248,920,000	10
1998	$248,920,000	10
1999	$301,150,000	10

Rationale for the Budget Request

The FY 2000 budget provides a total of $1,615,000,000 for the Substance Abuse Prevention and Treatment Block Grant. Of this total, 20%, or $306,850,000 represents the prevention set-aside to be used by States in implementing substance abuse prevention programs within the six categories listed above.

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D. CENTER FOR SUBSTANCE ABUSE TREATMENT
Overview

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$1,201,550,000	$1,376,468,000	$1,454,268,000	+ $77,800,000

Current information reported by SAMHSA underscores a significant disparity between the availability of treatment services for alcohol and drug abusers and the need for such services. Data indicate that 5.7 million Americans who are abusing or are dependent on drugs are severely in need of addiction treatment. Of these individuals, only 2.1 million can be served through the existing publicly funded treatment system, i.e., only 37 percent of those individuals in the United States who severely need substance abuse treatment are able to receive it, leaving a gap of 3.6 million untreated individuals.

There are several contributing factors to this Atreatment gap@: the introduction of managed care principles into publicly-funded treatment delivery systems; elimination of the drug addiction and alcoholism (DA&A) benefit for many individuals formerly eligible for Supplemental Security Income and Supplemental Security Disability Income; and, variability of access to treatment services. The most important factors, however, are insufficient financial resources devoted to treatment and stigma.

The financial resources needed to provide treatment services as presented in this budget submission are actually quite small when compared to the costs associated with alcohol and drug abuse. A study released in May 1998 by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) estimates that the economic cost of alcohol and drug abuse was $246 billion in 1992 (the most recent year for which sufficient data were available). Two-thirds of the costs of alcohol abuse is related to lost productivity, with most of the remaining costs being associated with health care expenditures, property and administrative expenditures of alcohol-related motor vehicle crashes, and alcohol-related crime.

The costs associated with drug abuse were distributed somewhat differently, with more than fifty percent of the costs being attributed to drug-related crime. These costs included lost productivity of victims and incarcerated perpetrators of drug-related crime; lost legitimate production due to drug-related crime careers; and other costs such as Federal drug traffic control, property damage, and police, legal, and corrections services. Most of the remaining costs were associated with premature death, lost productivity due to drug-related illness, and health care expenditures.

Among the highest health care expenditures for substance abusers are those associated with HIV/AIDS. Sharing syringes and other equipment for drug injection and unsafe sexual practices place these people at much greater risk for contracting HIV. Approximately one-third of new AIDS cases reported in 1997 were

injection drug user associated. Racial and ethnic minorities in the United States bear the heaviest burden of HIV disease related to drug injection. In 1997, IDU-associated AIDS cases made up 38% of all cases among African Americans and 37% of all cases among Hispanics, compared with 22% of cases among Caucasians. Furthermore, IDU-associated AIDS has a greater impact on women than men. Since 1981, at least 61% of all AIDS cases among women have been attributed to injection drug use or sex with partners who inject drugs, compared with 31% of cases among men (Centers for Disease Control and Prevention).

The treatment gap and the dramatically high costs of alcohol and drug abuse to our society are compelling reasons to allocate more resources to substance abuse treatment. Moreover, there is ample evidence that clearly demonstrates treatment works and is a sound investment for public dollars. Patients who enter treatment significantly reduce their use of illicit substances. The efficacy of drug treatment is documented in the National Treatment Improvement Evaluation Study (Center for Substance Abuse Treatment, 1996) as well as the Drug Abuse Treatment Outcome Study (National Institute on Drug Abuse, 1997). Both studies demonstrated that with every form of treatment, use of illicit drugs in the 12 months following treatment was significantly lower.

Studies in several States show that the impact of substance abuse treatment on State and local budgets is very significant. After looking at five years of data for those who completed treatment in Oregon, an Independent Survey of Treatment Payoffs (1996) showed that for every dollar spent on treatment, $5.60 is returned in public savings from reduced use of welfare, food stamps, Medicaid funds, crime, and reduced imprisonment.

In a Statewide study, Minnesota found that almost 80 percent of the costs for treating substance abusing clients are offset in the first year alone by reductions in medical and substance abuse hospitalizations, detoxification, and arrests. Minnesota estimates an annual savings of $39 million from reduced medical stays, residential treatment days, and detoxification admissions, as well as avoided DWI and other arrests.

The CALDATA study in California (1994) was even more notable in its conclusion: treatment pays for itself on the day in which it is delivered. This study found that for every dollar spent in outpatient or methadone treatment, the principal effect on funding was a cost benefit of $7 to the taxpayer and the economy during the same period.

CSAT improves the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost-effective addiction treatment that reduces the health and social costs to our communities and the nation. CSAT is the Federal organization charged with financing much of the treatment for individuals and families with alcohol and drug addiction problems. The Substance Abuse Prevention and Treatment (SAPT) Block Grant is the cornerstone of the States' substance abuse programs, accounting for 40% of public funds expended for treatment and prevention (1995). The SAPT Block Grant provides support for over 7000 community based treatment organizations across the U.S.

Implementation of SAMHSA Program Goals

CSAT programs support the four SAMHSA/GPRA program goals. CSAT=s Knowledge Development and Application Programs support Goal 1: Bridging the gap between knowledge and practice, and Goal 2: Promoting the adoption of best practices. For FY 2000, Goal 1 will be measured by the success of four programs for which performance information is provided in the GPRA plan: treating Adult Marijuana Users; Wraparound Services for Clients; Treating Teen Marijuana Users; and, Starting Early Starting Smart. Goal 2 will be measured by the success of the Addiction Technology Transfer Centers. Goal 3 will be measured by the success of the Substance Abuse Prevention and Treatment Block Grant and the Targeted Treatment Capacity Expansion program. Goal 4 will be measured by the success of the State Needs Assessment and Resource Allocation Program, and the Treatment Outcomes and Performance Pilot Studies.

CSAT plays a critical role in improving the level and quality of substance abuse treatment programs. In partnership with other Federal agencies, State and local governments, and community-based treatment providers, the Center is addressing issues of the changing nature of the drug problem, treatment efficacy, access, quality and accountability of substance abuse treatment services. CSAT=s FY 2000 portfolio is designed to build on the strengths of the current programs and initiatives, as follows:

- Assuring Service Availability While Meeting Targeted Needs - Only two million of over five million persons who use and abuse alcohol and other drugs (Level II Treatment Need; SAMHSA, Office of Applied Studies, 1996) can be served through existing publicly-funded treatment systems. Substance abuse patterns vary greatly regionally and locally across the United States, from increased heroin use in the Northeast, to methamphetamine use in the Southwest and Midwest. This fact, coupled with the significant gap between available treatment capacity and current demand, often impedes the existing treatment system=s ability to respond quickly to changing needs. A major objective of the National Drug Control Strategy is to close the treatment gap and reduce drug use by 50% by 2007. The FY 2000 request proposes increases for two programs which focus specifically on reducing the Atreatment gap@: (1) the SAPT Block Grant, which provides substance abuse treatment services nationwide ; and, (2) the Targeted Treatment Capacity Expansion program, which will provide rapid and strategic responses to the demand for alcohol and drug abuse treatment services that are more regional or local in nature. Examples of this might include communities with emerging serious drug problems, such as methamphetamine moving into the Midwest, or communities with innovative solutions that only require funding to address their unmet substance abuse treatment needs.

- Treating HIV/AIDS in Minority Communities - Another major emphasis of the Targeted Treatment Capacity Expansion funds, begun in FY 1999 and planned for continuation and expansion in FY 2000, is for certain minority populations at risk of contracting HIV/AIDS or living with HIV/AIDS.

These include substance abusing African American and Hispanic women and their children; substance abusing African American and Hispanic adolescent boys and girls; and substance abusing African American and Hispanic men. The goal of this program is to enhance and improve existing substance abuse treatment services for these populations in cities and States highly impacted by the twin epidemics of substance abuse and HIV/AIDS.

C Bridging the Gap Between Knowledge and Practice - The Institute of Medicine (IOM) recently completed a study, ***Bridging the Gap Between Practice and Research*** (1998), which addresses the value of the relationship between drug abuse research and the transfer of new knowledge to community based treatment organizations. Building on the research done by NIDA, NIAAA and others, the Exemplary Treatment Models Program and the Comprehensive Community Treatment Program, will provide CSAT the continued opportunity to work with treatment providers to improve access to and the effectiveness of treatment. In accordance with ONDCP=s National Drug Control Strategy, CSAT will focus on special populations and treatment settings which present unique challenges to the delivery of treatment services such as pregnant and parenting women, women involved with the welfare system, the dually diagnosed, and homeless substance abusers . Also reflective of ONDCP=s directives, CSAT will give special attention to treatment in the workplace, schools, and primary care settings as well as the criminal justice and juvenile justice systems.

C Promoting the Adoption of Best Practices - The National Drug Control Strategy focuses on improving treatment by raising the standards of practice in treatment to ensure consistency with research findings. The activities supported by CSAT provide a unique opportunity to translate clinical best practices into standard practice in publicly-funded programs, i.e., those programs funded by the SAPT Block Grant. The IOM study addresses how funding mechanisms can be used to foster the adoption of new and effective treatments. The IOM recommends that CSAT and the States A...cooperate in the development of financial incentives that encourage the inclusion of proven treatment approaches into community-based treatment programs.@ This initiative will allow State agencies responsible for administering the SAPT Block Grant to adopt best practices, thus enhancing the linkage between NIDA and NIAAA research and other CSAT discretionary activities.

C Enhancing Service System Performance - Improving outcomes for substance abusing clients is the core of CSAT=s mission. The development of data infrastructure at the program and State level is a crucial component in the production of data to determine client outcomes and program effectiveness. CSAT recognizes that many States are not currently collecting such data, that increased capability for such activity is required, and that significant resources will be required to effect the desired results. CSAT will continue, as resources allow, to build on the State Needs Assessment Program and the Treatment Outcome and Performance Pilot Studies (TOPPS), allowing for the standardization of methodology, definition and output, such that it is mutually beneficial and useful to Federal and State policy and funding decisions. Data infrastructure is an important component of

ONDCP=s performance measurement efforts in determining the impact of Federal, State and local efforts to reduce drug use.

Further description of these SAMHSA program goals may be found in Section A. General Statement/Overview.

Number of Persons Receiving Treatment with SAMHSA Funding

(Dollars in Thousands)

	1998 Actual	1999 Enacted	2000 Request	Increase in $ / Pers Svd 2000 vs 1999	Percent Increase 2000 vs 1999
SAMHSA Drug Treatment Funds	$793,446	$920,085	$987,617	$67,532	7.34%
Persons Served w/ SAMHSA Funds	339,631	383,858	403,603	19,746	5.14%

In all these efforts, CSAT=s goal is to make treatment efficient, cost-effective, and readily available to all those who need and want treatment services. The following two tables reflect the extent of the current need for treatment services, and the capability of programs supported by Federal funding to provide these services. As can be readily seen, a lot is being done, but there is still much more to do.

The substance abuse treatment field remains a dynamic one. Factors such as continuous quality improvement initiatives, shifts in the populations served, use of patient placement criteria, and requirements for outcome monitoring systems require new techniques and approaches to ensure delivery of state-of-the-art treatment services. To address these and other challenges facing us in the next century, CSAT is targeting funding to these areas to sustain efforts already begun.

Center for Substance Abuse Treatment

Detail Budget

(dollars in thousands)

	FY 1998 Actual		FY 1999 Enacted		FY 2000 Request	
Knowledge Development and Application:	**No.**	**Amt.**	**No.**	**Amt.**	**No.**	**Amt.**
Grants:						
Continuations	21	$17,248	51	$19,260	50	$10,803
Competing:						
New	35	6,943	22	5,500	---	---
Supplements:						
Administrative	4	355	---	---	---	---
Subtotal, Grants	60	24,546	73	24,760	50	10,803
Cooperative Agreements:						
Continuations	66	33,449	76	34,336	71	32,094
Competing:						
New	43	16,788	24	10,000	60	35,255
Supplements:						
Administrative	2	270	---	---	---	---
Competing		1	---	---	---	---
Subtotal, Coop. Agreements	111	50,508	100	44,336	131	67,349
Contracts	142	56,082	69	47,540	35	38,484
Total KDA	**313**	**131,136**	**242**	**116,636**	**216**	**116,636**
Targeted Treatment Capacity Expansion:						
Grants:						
Continuations	---	---	41	23,732	90	52,232
Competing:						
New	41	23,732	49	28,500	60 -90	55,000
Renewal	---	---	---	---	---	---
Subtotal, Grants	41	23,732	90	52,232	150 -180	107,232
Contracts	1	1,000	1	3,000	1	3,000
Total Targeted Treatment Capacity Exp	**42**	**24,732**	**91**	**55,232**	**151-181**	**110,232**
Substance Abuse Block Grant:						
Total, Substance Abuse Block Grant	**60**	**1,310,107**	**60**	**1,585,000**	**60**	**1,615,000**
Set-Aside (Non-Add)	---	65,505	---	79,250	---	80,750

D. CENTER FOR SUBSTANCE ABUSE TREATMENT
1. Knowledge Development and Application (KDA)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$131,136,000	$116,636,000	$116,636,000	---

2000 Authorization

PHSA Section 501 ..... Indefinite

Purpose and Method of Operation

CSAT supports activities of developing and field testing new treatment models in order to facilitate the provision of quality treatment services and service delivery. These activities are undertaken in actual service settings rather than laboratories and results are disseminated to State agencies and community treatment providers. The goal is to promote continuous, positive treatment service delivery change for those people who use and abuse alcohol and drugs.

Treatment is an effective method for addressing the problems of substance abuse. Through its current learning activities, CSAT has made a substantial investment in multi-year treatment enhancements. The 1999 budget continues to be based on the overall goal of improving services systems by providing effective service models and treatment approaches and reducing fragmentation of service delivery systems. Projects which are underway include:

- The ***Starting Early Starting Smart Program*** is a collaborative effort of a unique private-public partnership between the Substance Abuse and Mental Health Services Administration and its three Centers and the Casey Family Program and represents the kind of partnership that the Federal government is encouraging on the State and community levels. This program tests the effectiveness of integrating mental health and substance abuse prevention and treatment service with primary health care service settings, or with early childhood service settings, for children, ages birth to seven, and their families. The goal of integrating services is improvement, by working with the many systems serving clients to ensure they are receiving the full range of services within a coordinated, efficient system. This team approach will eliminate fragmentation and duplication in service delivery, and ensure that all service providers have full knowledge of pertinent information from all sources. See

GPRA plan for standard measures, and program specific measures, and update information.

- Another collaboration of all SAMHSA components is looking at ***Women and Violence***. This program is designed to review and develop new policy directions around the interaction of violence, substance abuse and mental health disorders in women. Phase One of the study, begun in FY 1998, consists of: 1) developing an integrated system of care with services intervention models; 2) implementing a qualitative evaluation; and, 3) developing evaluation protocols for the second phase. Phase Two is the actual implementation of the integrated strategies and services intervention models.

- In response to the recent rise in the use of marijuana among adolescents, and the fact that marijuana is the most commonly used and readily available illicit drug, CSAT supported a study examining the ***Effectiveness of Treatment for Marijuana Dependent Youth***. Building on NIDA research of brief treatment interventions for marijuana dependence, CSAT funded study sites to evaluate a variety of treatment interventions for adolescents. See GPRA plan for standard measures and program specific measures.

- The ***Criminal Justice Diversion*** study, a collaboration with the Center for Mental Health Services, is designed to identify methods for diverting individuals with substance abuse disorders from the criminal justice system to community treatment alternatives. Study sites compare outcomes for individuals who are diverted from the criminal justice system into community treatment programs with those who become involved in the criminal justice system without diversion to substance abuse treatment services. The primary outcomes to be assessed include criminal recidivism, time incarcerated, continuity of participation in treatment, emergency treatment utilization, and reduction of frequency of substance abuse.

- The ***Managed Care for Adolescents*** study is examining the effects on cost, utilization, and outcomes of different models of managed care regarding adolescents with substance abuse problems. This is a population with which managed care organizations typically have very limited experience. Similarly, there is little information about the provision of early intervention services, habilitation and rehabilitation services, or Awrap-around@ services for adolescents under managed care arrangements, or the relationship of the juvenile justice system to managed care plans. This program will focus on the impact of managed care on utilization, outcomes, and costs for substance abuse treatment of adolescents, examining specific impacts within subpopulations such as racial and ethnic minorities and adolescents involved with the criminal justice system.

- The use of illicit methamphetamine has been increasing, particularly on the West Coast, in the Southwest, and in the Midwest. As a consequence, more people are seeking treatment; however, there are no well established treatment approaches, and the few programs that have published results have not carried

out cost-effectiveness studies. The ***Replicating Effective Treatment for Methamphetamine Dependence*** study will contribute to the development of knowledge of psychosocial treatment of methamphetamine dependence as well as providing an opportunity to determine the problems involved in technology transfer. Additionally, the process will help support needed treatment in several communities impacted by increasing methamphetamine addiction. This program is designed to build upon data already gathered. The Matrix program in California has treated several hundred methamphetamine users in a well described, manualized outpatient based psychosocial approach. Under a CSAT contract, Matrix followed-up a sample of treated methamphetamine dependent patients and found that retention and outcomes were relatively good (about 40% abstinent for one year) and were comparable with cocaine dependent patients. The effectiveness of sites funded under this initiative would be compared to the original Matrix results to allow some estimate of the costs and problems of replicability.

- The ***Identification of Exemplary Treatment Models*** creates a partnership between States, communities, and the Federal government to explore the development of effective treatment approaches. This program is designed to stimulate States, local governments and private organizations to: 1) identify potentially exemplary models that currently exist; 2) document/manualize these models; 3) produce short-term evaluation of outcome measures; and 4) present these documented/manualized/evaluated programs to a Blue Ribbon Panel. Those programs identified as exemplary, because of their demonstrated cost effectiveness and highly successful client outcomes, will be offered for replication. It is expected that this program will facilitate the process of identification and transfer of knowledge and methodology to all Block Grant recipients and other treatment providers.

  One targeted population for this program is youth/young adults using heroin. There are increasing signs that heroin is re-emerging as a problem among youth and young adults. Data from the National Household Survey found that past month use of heroin increased from 25,000 to 45,000 individuals in the 12 to 17 year old age group between 1994 and 1995 (the most recent available data from the survey). The National Household Survey estimates of rates of first time use of heroin for age groups of 12-17 and 18-25 increased dramatically between 1993 and 1994. Data for 1995 from SAMHSA=s Drug Abuse Warning Network found heroin mentions in emergency departments to have increased among the 18-25 year group in six major cities, two of which did not have parallel increases in older age groups. Anecdotal information points to a significant upswing in heroin use among certain groups of youth and young adults who see the drug as chic. Heroin is widely available, relatively cheap and because of its purity can be smoked as well as injected. This makes it attractive because snorting allows the individual to get high without the use of needles and the concomitant threat of AIDS.

- In FY 1998, CSAT began a collaboration with NIAAA on a program focusing on ***Treatment for Adolescent Alcohol Abuse and Alcoholism***. Studies have shown that alcohol is frequently implicated in adolescent traffic deaths, suicides, homicides, and other fatal injuries. Risk for alcohol-related consequences appears to increase with each grade in school. Although a variety of interventions have been developed to ameliorate serious alcohol and alcohol-drug problems among adolescents, their

efficacy is largely untested. The purpose of this program is to contribute to the identification and development of efficacious treatment interventions for adolescent alcohol abusers and alcoholics. Projects will be identifying, developing and/or testing screening and diagnostic instruments for use in this population.

- The substance abuse treatment field, and service consumers and their families, benefit from the study of clinical and service delivery approaches that will result in more effective and efficient substance abuse treatment practice. Delivery of substance abuse treatment services is complicated by rapidly changing demographics of the persons needing and receiving services and of the communities in which the services are provided. In FY 1999, CSAT plans to award funds under the ***Comprehensive Community Treatment Program.*** This program is designed to examine more effective and innovative substance abuse treatment programs and approaches/models designed for both non-traditional and standard treatment settings. In addition, these projects will focus on special populations whose needs have not been well defined and addressed, and whose requirements for accessing and continuing with treatment are not yet known or well understood. Examples of these populations include adolescents, homeless, minorities, and women and their children.

- To ensure that those working in the treatment field have the knowledge needed, CSAT created a network of ***Addiction Technology Transfer Centers*** (ATTCs) which disseminate clinically relevant, research-based addiction knowledge. The ATTCs are multi-disciplinary in scope, encompassing addictions counseling and a minimum of three other related disciplines such as medicine, nursing, social work, marriage/family therapy, psychology, and criminal justice. They are also charged with working toward upgrading and standardizing credentialing and/or licensing requirements within the respective ATTC State(s) and developing or enhancing curricula to meet those requirements. See GPRA plan for standard measures and program specific measures.

  The ATTC Curriculum Committee produced the *Addiction Counselor Competencies* in 1995. A revised and expanded edition, *Addiction Counseling Competencies: the Knowledge, Skills, and Attitudes of Professional Practice*, developed with extensive input from the field, describes the educational outcomes essential to the competent practice of addiction counselors. The *Competencies* now serve as the basis of the National Association of Drug and Alcohol Counselors (NADAC) and the International Certification Reciprocity Consortium (ICRC) practice guidelines. This work has also been endorsed by the International Coalition of Addiction Studies Educators (INCASE) and the American Academy of Health Care Providers in the Addictive Disorders.

  The focus of the ATTC program, which was recompeted in FY 1998, is transferring technology from science to practice through knowledge development, dissemination, and application, incorporating such things as needs assessment, multi-disciplinary linkages, curricula development, and other special initiatives.

- Although many CSAT-funded projects have employed follow-ups of patients in their evaluation, post-treatment follow-up periods generally have not exceeded 12 months, so that longer term treatment benefits have not been established. Longer term studies offer the advantage not only of determining effectiveness over a period of several years, but the opportunity to examine the natural history of a chronic, relapsing disorder after an index treatment episode. The purpose of ***Persistent Effects of Treatment Studies*** (PETS) is to conduct a primary set of follow-up studies to evaluate the long-term effectiveness (up to 36 months) of substance abuse treatment services provided through a series of CSAT grants and cooperative agreements; and to conduct a number of special studies and policy analyses that address specific drugs of abuse, methods of treatment, populations or policy issues. The potential importance of this family of studies requires wide dissemination, through technical reports, professional journals and conferences. This will be accomplished through the ATTCs and other dissemination methods.

- The ***Accreditation of Opioid Treatment Programs (OTP)*** project was awarded in 1997. This accreditation/regulatory program will provide for more effective use of opioid therapies such as methadone treatment. Methadone treatment is one of the most effective treatment modalities for heroin addiction. Implementation and expansion of this Aworking laboratory@ in 1998 included development of a public-private partnership for accreditation of OTPs. During the remaining year of the 3-year project period, CSAT will use the accreditation systems to assess how this model can provide the Secretary with data to fulfill the statutory requirement to determine whether an OTP meets DHHS standards. In turn, this DHHS Acertification@ or Adetermination of qualification@ would serve as one of the data elements which the Drug Enforcement Agency evaluates before registering an OTP. With rates of heroin use now increasing, pressure to admit more patients to OTPs is likely to increase. Working with FDA, DEA, NIH/NIDA, ONDCP and other Federal agencies, this project will elicit the involvement of external, private agencies with clinical experience in accreditation of health care programs and facilities as a means of improving treatment and treatment outcomes in the field of opioid addiction.

  A second activity which began in 1997 is the ***Evaluation of the Accreditation for Opioid Pharmacotherapy*** programs. The goal of this evaluation is to obtain information that can guide the full national implementation of the new accreditation system for OTPs through systematic study of the processes, barriers, and costs associated with a change from a regulatory to an accreditation/regulatory process, and the impacts on methadone diversion, program accessibility, client populations served, staff attitudes and behavior and patient satisfaction and outcomes.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995	$208,464,000	---
1996	89,777,000	---

1997	155,868,000	---
1998*	131,136,000	---
1999*	116,636,000	---

* Excludes funds transferred to the Targeted Capacity Expansion budget line.

Rationale for the Budget Request

A total of $116.6 million is requested for these activities in FY 2000, the same level as FY 1999. This funding level will provide for continuation of 121 current grants/cooperative agreements and allow approximately $35.3 million for an estimated 50 new awards.

Past CSAT activities, as well as research from NIDA and NIAAA, point to a need to develop and modify treatment approaches for special populations and service settings. The need stems from various factors, such as drug of choice, age, gender, culture, ethnicity, and involvement in other systems such as welfare and criminal justice, as well as Federal, State and local health care policies and programs. The programs proposed for FY 2000 are designed to determine what changes in practice are necessary to achieve improved outcomes, what impact those changes have on client outcomes, and what treatment outcomes can be expected from specific interventions.

The ***Exemplary Treatment Models Program,*** first funded in FY 1998, focused solely on adolescents. By Aexemplary,@ CSAT means programs which have been validated as exemplary through formal evaluation or research as evidenced by the availability of peer-reviewed empirical findings; have significant consensus among experts, including evaluators, policy-makers, providers, consumers and families that they are exemplary; have been or can be reasonably expected to be generalizable with adaptation to local circumstances; and are documented. The purpose of the program is to identify currently existing models of treatment for critical populations, which when evaluated for client outcomes and cost, demonstrate effectiveness in treating that population. This program is a two-phased activity designed to identify those effective regimens of care (Phase I) for further replication (Phase II) and dissemination. Through Phase I, the treatment program will be validated as being effective. Effective treatment models that are exemplary will demonstrate cost-effectiveness, as well as highly successful individual client outcomes. Both of these indices will be used in the determination of models felt worthy of replication (Phase II).

CSAT proposes to publish again the Exemplary Treatment Models Program in FY 2000 to initiate the second phase of the program for adolescents with substance abuse problems---replication of exemplary treatment models. CSAT proposes to include two additional populations for Phase I study: women receiving Temporary Assistance to Needy Families (TANF) and individuals with co-occurring psychiatric and substance abuse disorders. Also, CSAT proposes to evaluate treatment approaches using behavioral contracting. It is expected that as a result of this program, 50% of clients served will have reduced substance use at one year follow-up.

Relationship to National Drug Control Strategy: This initiative supports the ONDCP Performance Measures and Effectiveness (PME) goals, objectives and targets. Specifically, it supports Goal 3: Reduce health and social costs to the public of illegal drug use; Objective 1: support and promote effective, efficient, and accessible drug treatment; Objective 5: support research into the development of treatment protocols to prevent or reduce drug dependence and abuse.

Goal 3 of the National Drug control Strategy seeks to reduce health and social problems which result from substance use and abuse. The ***Comprehensive Community Treatment Program*** is designed to establish a mechanism by which treatment providers and other experts in the treatment field can identify innovative clinical and service delivery approaches in need of development and study. This program also takes into account the recommendations of the IOM study, ***Bridging the Gap Between Practice and Research***, which include developing an infrastructure to facilitate research within community based treatment programs. CSAT will support the development and/or evaluation of four types of projects: treatment interventions for special populations; integrated treatment settings; specialized substance use disorder treatment for people with physical and cognitive disabilities; and, innovative care delivery models.

Special Populations - Changing demographics in the general population and among addicted people has prompted service providers and policy makers to modify traditional addiction treatment to best meet the needs of people from special populations (i.e., pregnant and parenting women, racial and ethnic minorities, children of substance abusing parents, people with physical and cognitive disabilities, youth, substance abusers with co-occurring mental disorders, and the homeless). Research has yet to identify adequately specific treatment needs of patients, related to their inclusion in a special population, or to describe the optimal treatment interventions or care delivery systems to best meet their needs. In particular, advocates have called for making the addiction treatment system culturally responsive, appropriate, and sensitive. To address these issues, CSAT must examine several areas related to the treatment of addicted patients from special populations such as: 1) the distinctive needs of addicted patients in special populations; 2) the treatment interventions that best meet the needs of patients from special populations; 3) the optimal approaches and delivery of treatment interventions that best meet the needs of patients from special populations; 4) the treatment outcomes for addicted patients from special populations in programs specifically designed for them; and, 5) the treatment outcomes for addicted patients from special populations who are treated in general addiction treatment programs.

Integrated Treatment Settings - Research provides strong evidence that the general population of addicted patients experiences significant, meaningful, and positive changes in biopsychosocial functioning following addiction treatment, irrespective of treatment setting. However, drug treatment has traditionally been provided primarily in four treatment settings: inpatient hospitals; residential treatment; intensive outpatient treatment programs; and outpatient treatment settings. Data and dramatic changes in the health care environment suggest that clinical intervention models need to be developed for settings other that those

in which treatment has been traditionally provided. CSAT proposes in FY 2000 to develop brief intervention and treatment models for the workplace, schools, and the primary health care system.

Innovative Care Delivery Models - In some ways, treatment outcomes research that focuses on treatment setting often promotes an artificial portrayal of treatment as being either inpatient or outpatient. From both a research and policy perspective, it is critical to consider various treatment settings and approaches as part of a comprehensive continuum of care, rather than as competitive strategies. Although research points us in the direction of integrating services and systems, health and social service systems have largely operated independently of each other. In FY 2000, CSAT proposes to develop innovative service delivery models designed to meet the diverse needs of treatment populations. Delivery models to be developed and/or evaluated will address issues such as HIV/AIDS and other medical services, rural health, treatment on demand, physician-based opioid treatment, clients with criminal justice involvement, community outreach, and home health treatment.

This program invites the substance abuse treatment field to identify and suggest treatment approaches and delivery models for study. It will give the field an opportunity to determine what treatment approaches are appropriate for a wide variety of special populations and treatment issues, as well as propose methods for evaluating their effectiveness. It will require linkages, as appropriate, to services within the community which have largely operated independently of each other to address comprehensively the unique needs of substance abusers. Client outcomes such as employment, reduced involvement with the criminal justice system, school attendance, and stable housing will be assessed. It is expected that as a result of this program, 50% of clients served will have reduced substance use at one year follow-up.

Relationship to National Drug Control Strategy: This initiative supports the ONDCP Performance Measures and Effectiveness (PME) goals, objectives and targets. It supports Goal 3: Reduce health and social costs to the public of illegal drug use; Objective 1: support and promote effective, efficient, and accessible drug treatment; Objective 2: reduce drug-related health problems; Objective 5: support research into the development of treatment protocols to prevent or reduce drug dependence and abuse.

The Substance Abuse Prevention and Treatment Block Grant is the cornerstone of public funding for substance abuse treatment programs. This vital resource is indispensable to State efforts to maintain viable treatment programs and to respond to the needs of those citizens who are at greatest risk for alcohol and drug abuse. It is incumbent upon CSAT to ensure that these funds are used for the maximal benefit of the persons who are served by public sector treatment programs. The need for publicly-funded treatment programs to produce positive clinical outcomes through their State-funded treatment programs may require enhancing the performance of many programs. CSAT=s programmatic and dissemination activities provide a unique opportunity to translate clinical best practices into standard practice in publicly-funded programs. As previously mentioned, the Institute of Medicine recommends that CSAT and the States cooperate to Aencourage the inclusion of proven treatment approaches into community-based treatment programs. This approach should include making additional funds available for implementing targeted treatment approaches.@

The intent of the proposed ***Implementing Best Practices Program*** is to support the type of initiative recommended by the IOM, to transfer treatment Abest practices@ to the community-based providers funded by the SAPT Block Grant. As an example, one State has begun to implement a screening and assessment tool which, when used to make placement decisions, has led to better outcomes for clients. The State has begun to implement this new tool in a few jurisdictions only, because it does not have sufficient financial resources to achieve Statewide implementation. This is one clear-cut example of how Federal resources could be used to support implementation of a best practice Statewide that would improve client outcomes.

The program will require States to identify populations to be served, to document that the project will improve services to populations identified, and to project any increased efficiencies resulting from practice improvements. This program will enhance the linkages between NIDA and NIAAA research, CSAT=s discretionary portfolio, and State systems development (funded through the SAPT Block Grant). The project will measure success based on the degree to which State systems have incorporated these best practices in publicly-funded programs and have demonstrated the implementation of these practices through the reporting of client outcome data.

Relationship to National Drug Control Strategy: This initiative supports the ONDCP Performance Measures and Effectiveness (PME) goals, objectives and targets. This initiative supports Goal 3: Reduce health and social costs to the public of illegal drug use; Objective 1: support and promote effective, efficient, and accessible drug treatment.

CSAT will also support Agency-wide initiatives on *Underage Drinking* and *Violence Against Women* using funds made available from expiring projects, as follows:

- **Underage Drinking Initiative:** CSAT=s primary role in the **National Agenda Against Underage Drinking** will be related to the generation of new empirical knowledge about what brief intervention and treatment models and associated services are most effective for brief intervention or treatment of alcohol use, misuse, and abuse in the cited underage populations.

- **Violence Against Women Initiative:** The activities included in this initiative will build on SAMHSA=s previous gender specific treatment efforts with women. This initiative seeks to discover what works to improve women=s outcomes in the utilization of substance abuse treatment services and to promote the improved coordination of services by developing an integrated services approach to organizing and institutionalizing coordinated social service delivery systems. The initiative will assess outcome, effectiveness and cost-effectiveness of the integrated service delivery systems. The initiative will also apply what is known to enhance and evaluate the effectiveness of treatment service delivery systems for women, specifically targeting underserved populations with addictive disorders. It will primarily focus on several diverse racial/ethnic populations, including African Americans, Latinos/Hispanics,

American Indian/ Alaska Natives, and Asian American/Pacific Islanders, as well as include a component to address immigrants, women with disabilities, and other special populations.

D. CENTER FOR SUBSTANCE ABUSE TREATMENT
2. Targeted Capacity Expansion (TCE)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$24,732,000	$55,232,000	$110,232,000	+ $55,000,000

2000 Authorization

PHSA Section 501 ..... Indefinite

Purpose and Method of Operation

Current information reported by SAMHSA underscores a significant disparity between the availability of treatment services for alcohol and drug abusers and the need for such services. Additionally, substance abuse patterns vary greatly regionally and locally across the United States. The Aregionalization@ of patterns, coupled with the significant gap between available treatment capacity and current demand, impede the existing treatment system=s ability to respond quickly to changing needs.

In FY 1998, CSAT awarded forty-one grants to municipal, county, State, and tribal governments to help close the gap in treatment for emerging substance abuse problems. This program will provide services for substance abusing women and their children, clients participating in welfare reform programs, juvenile and adult criminal justice-referred offenders, dually diagnosed offenders, substance abusing physically and cognitively challenged individuals, and hard-to-reach intravenous drug users.

In FY 1999, CSAT was also appropriated funds to address the issue of the crisis that exists with respect to the extent and impact of HIV/AIDS on the Black community as highlighted by members of the Congressional Black Caucus (CBC). In response to this issue and the increasing AIDS case rate among minorities, CSAT plans to award grants to augment, expand and enhance substance abuse treatment services that include an HIV component. These grants will be restricted to metropolitan areas with AIDS case rates of 25 per 100,000 or higher and States with AIDS case rate of 10 or more per 100,000 (as reported in the CDC=s HIV/AIDS Surveillance Report). These funds will be earmarked for comprehensive substance abuse treatment programs for substance abusing African American and Hispanic populations at risk of contracting HIV, including women and their children, adolescents, and men who have sex with men (MSM).

The 1998 National Drug Control Strategy places emphasis on closing the treatment gap in an effort to reduce drug dependence by 50% by the year 2007. The Targeted Treatment Capacity Expansion program

was designed to address gaps in treatment capacity by supporting rapid and strategic responses to demand for alcohol and drug abuse treatment services. The response to treatment capacity problems may include communities with serious, emerging drug problems or communities struggling with unmet need.

Funding levels for the past five fiscal years were as follows:

	Funding	FTE
1995	---	---
1996	---	---
1997	---	---
1998*	$24,732,000	---
1999*	55,232,000	---

* Reflects funding transfer from the Knowledge Development and Application Program budget line.

Rationale for the Budget Request

In support of ONDCP=s goal of reducing the treatment gap, CSAT is requesting $110.2 million for this program in FY 2000, an increase of $55.0 million over FY 1999.

This initiative moves us closer to eliminating the treatment gap and providing substance abuse treatment services for all those who need and want such services with a corresponding reduction in health and social services costs resulting from substance dependence and abuse. Program measures will include the number of clients served who were actually served as well as a goal that 50% of the clients served will have reduced substance use at one year follow-up.

In FY 2000, CSAT proposes to award new grants in order to begin the process of reducing the waiting time for entry into treatment as well as reducing the treatment gap by providing services for those in need. The type of issues this program will allow States and communities to address could range from a longstanding need for treatment services in the target area, to a change in local substance abuse patterns, to the implementation of an alternative sentencing program. The goal of this program is to create or expand the ability to provide an integrated, creative and community-based response to a targeted, well-documented substance abuse treatment capacity problem. This program will provide States and communities the opportunity to meet the needs of special populations (i.e., persons suffering from HIV/AIDS, homeless, and adolescents).

This initiative also relates to the Administration=s Empowerment Zone/Enterprise Community (EZ/EC) Program. A major goal of the EZ/EC is the implementation and evaluation of new approaches for issues facing children and families in these and similar neighborhoods. The Targeted Treatment Capacity

Expansion Program is designed to create or expand a community-s ability to provide an integrated and community-based response to targeted problems. The funded programs are to coordinate with such resources as: community focused educational and preventive efforts; school based activities such as after school programs; private industry supported work placements for recovering persons; faith based organizational support; and involvement of ethnocentric community resource centers. It is meant to be a coordinated effort to address the spectrum of health and human services issues experienced by communities as a result of substance abuse and dependence.

Relationship to National Drug Control Strategy: This initiative supports the ONDCP Performance Measures and Effectiveness (PME) goals, objectives and targets. Specifically, it supports Goal 3: Reduce health and social costs to the public of illegal drug use; Objective 1: support and promote effective, efficient, and accessible drug treatment by reducing the treatment gap; Objective 2: reduce drug-related health problems; Objective 3: promote national adoption of drug-free workplace programs that emphasize a comprehensive program that includes intervention.

D. CENTER FOR SUBSTANCE ABUSE TREATMENT
3. Substance Abuse Prevention and Treatment Block Grant (SAPTBG)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA				
Total	$1,360,107,000	$1,585,000,000	$1,615,000,000	+ $30,000,000
Treatment.....	($1,045,682,000)	($1,204,600,000)	($1,227,400,000)	(+ $22,800,000)

Note: FY 1998 includes the $50 million SSI Supplement provided by P.L. 104-121.

2000 Authorization

Substance Abuse Block Grant ..... Expired

Purpose and Method of Operation

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds are distributed to the States for the purposes of supporting treatment and prevention services for alcohol and other drug abuse. New legislation has been submitted; however, the program continues to be authorized by current law (P.L. 102-321, the ADAMHA Reorganization Act). The SAPTBG is a formula-driven grant, and it includes the following mandatory distributions and set-asides for allocations made to the States:

- **35%** must be used for ALCOHOL prevention and treatment activities; and,
- **35%** must be used for OTHER DRUG prevention and treatment activities.
- The remaining **30%** is used at the discretion of the State for either alcohol or drug activities..
- In addition to the above, the law further states that:
  - **20%** must be used for **prevention** activities (estimated at $323 million for 2000).
  - **2% - 5%** must be spent on HIV/AIDS-related substance abuse programs in States with AIDS case rates of 10 or more per 100,000 population (reported at $54.2 million for latest year available).
  - **up to 5%** of a State=s allocation may be used for State administration (maximum of approximately $75 million in 1999).

- States must spend from their allocation an amount equal to fiscal year 1994 spending levels on programs for pregnant women and women with dependent children (reported at $195 million for latest year available).

- These sub-allocations *are not separate and distinct*; they *overlap* the basic mandates. The law also requires States to routinely make available TB services, provide preference in admissions to treatment facilities for pregnant women, and, provide admission to treatment within 14-120 days for intravenous drug users.

- **5%** of the total SAPT Block Grant is authorized to be used for the federal set-aside, which supports data collection, technical assistance, and program evaluation (approximately $80.8 million for FY 2000).

The SAPT Block Grant is the cornerstone of the States= substance abuse programs, accounting for 40% of public funds expended for treatment and prevention (1995). As reported on the block grant applications, Federal funding for public treatment facilities, as a percentage of all funding being used at State-level for substance abuse treatment, ranges from a low of 11% in one State to a high of 84% in another. In 1997, nineteen States reported that they received the majority of their funding for support of substance abuse treatment services from the SAPT Block Grant. Based on the total of all States treatment structures, over 7,000 community based organizations (CBOs) receive SAPT Block Grant funding.

Based on a study by SAMHSA=s Office of Applied Studies, it is estimated that in 1997, there are 5.7 million Americans with serious drug abuse or dependency problems who are in need of addiction treatment. The primary focus of Federal funding is on this category of persons who need treatment. Of these individuals, only 2.1 million can be served through the existing publicly-funded treatment system, i.e., only 37 percent of those individuals who need substance abuse treatment in the U.S. receive it from Federally supported programs, a gap of 3.6 million individuals. The 1999 appropriation will support treatment for approximately 384,000 drug-abusing persons, an increase of more than 44,000 over 1998. CSAT does not have estimates for the number of persons who would benefit from treatment for abuse of alcohol, but, as noted above, at least 35% of the SAPT Block Grant must by used to provide prevention and treatment programs for this group.

Data Elements Used to Calculate State Allotments

FY 1999: The 1999 State allotments under the SAPT Block Grant were determined after implementing the minimum allotment provisions of the Appropriation Act for fiscal year 1999. Section 218 of Public Law 105-277 permitted the Secretary to implement current law including the change to the use of non-manufacturing wages but established minimum allotments. The general principles of the minimum allotments were that:

1. No State would be allotted less than 105 percent of what they received in fiscal year 1998; and

2. No State would receive less than 0.375 percent of the total amount appropriated for the SAPT Block Grant, except that if a State benefited from this provision, it could not receive an increase in its allotment over what it received in fiscal year 1998 of more than 49.6 percent.

The 1999 State allotments were generated using the following factors:

C Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA website, Personal Income by State and Region, for years 1994-1996.

C Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, Annual Time Series of Population Estimates by Age and Sex, By Single Year of Age and Sex, data as of 7/1/1996.

C Total Taxable Resources (TTR) for years 1994-1996 - Office of Economic Policy, Department of the Treasury, provided directly to OAS.

C Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were included in the 1990 census.

C A Cost of Services Factor which includes the following: Fair Market Rents for the Section 8 Housing Assistance Payments Program **C** Fiscal year 1997, from the U.S. Department of Housing and Urban Development, *Federal Register*, September 20, 1996, Vol. 61, No. 184, pages 49576-49635, from website *http://www.hud.gov* and then *ftp@ftp.aspemsys.com*. 1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1993 hourly hospital wages developed from the FY 1997 HCFA Hospital Inpatient Prospective Payment System Wage Rates [published in the *Federal Register*, August 30, 1996, Vol. 61, Number 170, pages 46165-46215 with corrected data published in the *Federal Register* December 19, 1996, Vol. 61, Number 245, pages 66919-66923] in the HCFA public use file AHCFA Hospital Wage Index Survey File@ of Hospital Inpatient Prospective Payment System FY 1997 Rates downloaded from website *http://www.hcfa.gov/stats/pufiles.htm* and corrected per the December 1996 revisions.

FY 2000: Since the minimum allotment provisions of P.L. 105-277 applied only to fiscal year 1999 funds, State allotments for FY 2000 will be determined using current law including the use of non-manufacturing wage data in calculating the cost of service factor. The factors that were used in producing the FY 2000 allocations are:

- Total Personal Income (TPI) - Bureau of Economic Analysis, Department of Commerce, downloaded from BEA website *http://www.bea.doc.gov/bea/dr/spitbl-d.htm#table2* - Table 2, Personal Income by State and Region, 1993-1997, release date 9/14/98, also available from *hhtp://www.bea.doc.gov/bea/ar1098rem/table1.htm.*

- Resident Population - Bureau of the Census, Department of Commerce, downloaded from Census website, text file AG9797.txt, 1990-to-1997 Annual Time Series of Population Estimates by Age and Sex, By Single Year of Age and Sex, public release date 7/21/98. Census website is *http://www.census.gov/population/estimates/state/stats/ag9797.txt*. (data as of 7/1/97).

- Total Taxable Resources (TTR) - Office of Economic Policy, Department of the Treasury, provided directly to OAS via e-mail, filename NM98EST.wk4, release date 9/30/98, Total Taxable Resources, 1994-1996.

- Population data for the territories based on 1990 Census Data except Micronesia and the Marshall Islands. Population data for Micronesia and the Marshall Islands are based on 1980 census data and the average rate of population change from the 1980 to the 1990 census. Because Micronesia and the Marshall Islands had entered into a Compact of Free Association with the United States, they were no longer considered territories in 1990 and therefore were included in the 1990 census.

- A Cost of Services Factor which includes the following: Fair Market Rents for the Section 8 Housing Assistance Payments Program **C** Fiscal year 1997, from the U.S. Department of Housing and Urban Development, *Federal Register*, September 20, 1996, Vol. 61, No. 184, pages 49576-49635, from website *http://www.hud.gov* and then *ftp@ftp.aspemsys.com*. 1990 Census mean hourly wages for selected industries and occupations (special data file prepared by the Bureau of the Census) updated using the percent change for HCFA mean hourly hospital wages (unadjusted) for FY 1990 (from a special data file prepared by the Health Care Financing Administration) and FY 1993 hourly hospital wages developed from the FY 1997 HCFA Hospital Inpatient Prospective Payment System Wage Rates [published in the *Federal Register*, August 30, 1996, Vol. 61, Number 170, pages 46165-46215 with corrected data published in the *Federal Register* December 19, 1996, Vol. 61, Number 245, pages 66919-66923] in the HCFA public use file AHCFA Hospital Wage Index Survey File@ of Hospital Inpatient Prospective Payment System FY 1997 Rates downloaded from website *http://www.hcfa.gov/stats/pufiles.htm* and corrected per the December 1996 revisions.

Funding levels for the past five fiscal years were as follows:

	Total Funding	Treatment Portion	FTE
1995	$1,234,107,000	$ 937,922,000	18
1996	1,234,107,000	937,922,000	18
1997*	1,360,107,000	1,045,682,000	18
1998*	1,360,107,000	1,045,682,000	18
1999	1,585,000,000	1,204,600,000	18

* Includes the $50 million SSI Supplement provided by P.L. 104-121.

Rationale for the Budget Request

The Office of National Drug Control Policy 1998 Strategy established a goal of closing the drug treatment gap by 50% by the year 2007. Reaching this goal will require a substantial infusion of additional Federal dollars to increase treatment capacity, as well as to provide the necessary funding for maintenance of current State treatment capacity levels. The proposed budget request of $1.615 billion represents an increase of $30 million, or less than 2% over the 1999 level. The request will allow States to maintain most core services currently in place, but provides little growth opportunity.

The SAPT Block Grant supports the ONDCP Performance Measures and Effectiveness (PME) goals, objectives and targets. Specifically, it supports Goal 3: Reduce health and social costs to the public of illegal drug use; Objective 1: support and promote effective, efficient, and accessible drug treatment by reducing the treatment gap; and, Objective 2: reduce drug-related health problems. See GPRA plan for the standard measures and program specific measures.

Substance Abuse Prevention and Treatment Block Grant, FY 1998 - 2000

State / Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Alabama	$18,766,069	$21,666,850	$23,029,304	$1,362,454
Alaska	2,045,493	3,440,623	3,508,531	67,908
Arizona	20,008,843	27,127,147	27,443,344	316,197
Arkansas	9,459,892	11,280,281	11,759,962	479,681
California	189,177,170	216,995,385	231,651,607	14,656,222
Colorado	19,331,042	20,297,398	21,003,025	705,627
Connecticut	15,049,798	16,405,660	16,322,946	-82,714
Delaware	3,712,142	5,553,544	3,557,177	-1,996,367
District Of Columbia	3,310,456	4,952,603	3,178,596	-1,774,007
Florida	56,125,849	80,256,078	84,309,814	4,053,736
Georgia	30,207,385	40,710,806	42,948,399	2,237,593
Hawaii	6,382,425	6,810,019	7,245,631	435,612
Idaho	4,865,185	5,943,750	6,070,285	126,535
Illinois	57,457,219	61,138,459	63,498,400	2,359,941
Indiana	30,961,391	32,509,147	31,040,567	-1,468,580
Iowa	11,945,086	12,542,219	12,365,313	-176,906
Kansas	10,472,687	10,996,215	11,474,551	478,336
Kentucky	16,449,566	19,105,313	19,998,565	893,252
Louisiana	22,361,950	24,828,318	25,519,161	690,843
Maine	5,066,439	5,943,750	5,446,931	-496,819
Maryland	27,488,907	29,389,161	30,368,193	979,032
Massachusetts	31,633,006	33,214,336	31,776,720	-1,437,616
Michigan	53,819,688	56,510,128	52,884,766	-3,625,362
Minnesota	19,883,464	20,877,637	20,620,293	-257,344
Red Lake Indians	490,054	514,557	508,215	-6,342
Mississippi	11,250,304	13,142,417	13,677,588	535,171
Missouri	22,195,118	24,121,029	25,131,060	1,010,031
Montana	3,732,709	5,584,314	4,253,481	-1,330,833
Nebraska	6,066,301	7,472,914	7,716,200	243,286
Nevada	7,034,109	9,441,768	9,980,280	538,512
New Hampshire	4,591,261	5,943,750	4,373,760	-1,569,990
New Jersey	39,985,543	45,115,909	46,306,388	1,190,479
New Mexico	6,779,047	8,261,541	8,452,837	191,296
New York	89,362,659	104,711,026	107,521,293	2,810,267
North Carolina	29,096,347	33,404,937	34,943,353	1,538,416
North Dakota	2,551,489	3,817,151	3,247,488	-569,663
Ohio	61,964,608	65,062,211	56,870,356	-8,191,855
Oklahoma	14,377,331	16,185,602	17,180,487	994,885
Oregon	14,395,138	15,114,749	15,840,383	725,634
Pennsylvania	54,924,670	57,670,348	58,675,612	1,005,264

Substance Abuse and Mental Health Services Administration

Substance Abuse Prevention and Treatment Block Grant, FY 1998 - 2000

State / Territory	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate	Difference +/- 2000 vs 1999
Rhode Island	4,590,879	5,943,750	5,516,590	-427,160
South Carolina	16,305,940	18,527,032	19,363,208	836,176
South Dakota	2,359,415	3,529,799	3,083,604	-446,195
Tennessee	21,411,878	25,624,806	26,973,862	1,349,056
Texas	89,219,174	122,543,553	128,770,182	6,226,629
Utah	10,785,895	13,729,782	15,097,359	1,367,577
Vermont	2,522,716	3,774,105	2,466,954	-1,307,151
Virginia	30,975,563	39,245,298	40,382,793	1,137,495
Washington	29,198,240	30,769,108	32,921,467	2,152,359
West Virginia	8,033,238	8,434,819	8,530,893	96,074
Wisconsin	23,362,586	24,530,479	24,716,982	186,503
Wyoming	1,639,236	2,452,377	1,711,494	-740,883
State Sub-total	**1,275,182,600**	**1,483,163,956**	**1,511,236,250**	**28,072,294**
American Samoa	226,342	263,259	268,242	4,983
Guam	644,346	749,439	763,624	14,185
Northern Marianas	209,754	243,965	248,583	4,618
Puerto Rico	17,043,767	19,823,590	20,198,800	375,210
Palau	73,178	85,113	86,724	1,611
Marshall Islands	216,480	251,788	256,554	4,766
Micronesia	512,483	596,069	607,351	11,282
Virgin Islands	492,671	573,026	583,872	10,846
Territory Sub-total	**19,419,021**	**22,586,250**	**23,013,750**	**427,500**
SAMHSA Set-Aside	**65,505,379**	**79,249,794**	**80,750,000**	**1,500,206**
GRAND TOTAL	**$1,360,107,000**	**$1,585,000,000**	**$1,615,000,000**	**$30,000,000**

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E. SUBSTANCE ABUSE BLOCK GRANT (SET-ASIDE)

Authorizing Legislation - New legislation has been submitted.

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA.....	$65,505,379	$79,249,794	$80,750,000	+$1,500,206

2000 Authorization

Substance Abuse Prevention and Treatment Block Grant ..... Expired

Purpose and Method of Operation

The 5% set-aside of the Substance Abuse Prevention and Treatment Block Grant (SAPT) supports data collection, technical assistance, the National Data Center, and program evaluation. SAMHSA is the major source of information in the United States on the extent and nature of substance abuse, the supply and cost of services for treating substance abuse, and the number and characteristics of persons in treatment. Much of this information is produced by data systems developed and managed by the Office of Applied Studies (OAS), the Center for Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). They are used by the Department of Health and Human Services, the Office of National Drug Control Policy, the Drug Enforcement Agency, and State and local agencies to plan and evaluate programs to address health and social problems.

Office Applied Studies (OAS)

Four major surveys provide the information used to formulate substance abuse policy and to evaluate performance of programs and activities supported with Federal funds. These surveys include: (1) the National Household Survey on Drug Abuse (NHSDA); (2) the Drug Abuse Warning Network (DAWN); (3) the Drug and Alcohol Services Information System (DASIS); and (4) the Alcohol and Drug Services Survey (ADSS). All of these data collection activities provide information required by Section 505 of the Public Health Service Act.

Expanded National Household Survey on Drug Abuse. The National Household Survey on Drug Abuse (NHSDA) is the largest and most widely known of the data collection activities of the Office of Applied Studies. This survey provides estimates of the prevalence of substance abuse and the number of persons who have received treatment in the civilian, non-institutionalized population. The NHSDA has been the principal source of this information since 1971. As a result, the data from this survey are employed to study trends in the use of and the attitudes about licit and illicit drugs. They also provide a unique source of information for studying the causes of substance abuse, the demand for treatment, and the effectiveness

of prevention and treatment programs. These studies are carried out by staff in OAS and by researchers in the public and private sectors.

The majority of Federal funds dedicated to substance abuse treatment and prevention are distributed directly to States. States decide what programs and activities receive funds and the level of support within the requirements established by legislation. Differences between States with respect to how these funds are allocated; their policies on prevention, treatment, and enforcement; and the populations at risk make it difficult to assess the results of these Federal expenditures.

The problem of evaluating the impact of Federal substance abuse programs is made more difficult by the nature of the information available for analysis. Only national or regional estimates can be obtained from such major sources of data as the NHSDA and Monitoring the Future (MTF) because of the size of the samples. On the other hand, data collected by some States and local entities to make small area estimates use methods that vary to such an extent they cannot be used to make State to State comparisons, develop regional estimates, or even, in many cases, track trends in the same State over a period of time.

To address these problems and generate data more appropriate for studying the impact of Federal expenditures for substance abuse treatment and prevention programs, the size of the NHSDA sample will increase to about 70,000 respondents in 1999. In 1996, the sample size of the survey was 18,000. In 1997 and 1998, the sample was expanded to 25,000 to oversample in Arizona and California. With the change and modifications in the sample design in 1999, it will be possible to produce State level estimates on an annual basis. Because questionnaires and survey methods will be the same in every State, the new survey will allow comparisons between States with respect to prevalence of substance abuse and other measures, will support the analysis of State trends over time, and by accumulating several years of information for each State, will even support estimates of intra-state variations. The new estimates will not only facilitate the evaluation of SAMHSA programs, over time they will also make it possible to direct Federal funds to areas with severe or unique problems.

The NHSDA will continue to provide national estimates of the incidence and prevalence of substance abuse, the nature of the substances, and the personal and family characteristics of those involved. The increase in the sample size will make these estimates more precise than in the past, enhance the analytic value of the data, and produce better estimates of the somewhat less common types of substance abuse. However, States will in most cases have to conduct surveys and analyses to address sub-state issues and special populations issues.

The 1999 NHSDA went into the field in January, 1999. The design calls for approximately 3800 interviews in the 8 largest States which together contain more than 50% of the U.S. population. Approximately 900 respondents will be interviewed in the other 42 States and the District of Columbia. Because the survey will focus on youth, approximately 280,000 households will have to be screened to identify eligible respondents. Studies have shown that face-to-face interviews are essential for obtaining information on

sensitive subjects such as substance abuse and mental health. Personal interviews are also required when the characteristics of respondents and other members of the household unit are important analytic variables.

The strategy for the expanded survey will produce direct estimates for the 8 largest States and model based estimates for the other 42 States. The information obtained from the 900 respondents in each of the latter States will be used to adjust the modeled estimates to take into account the individual characteristics of each State. Although the small size of the State-specific samples will limit the precision of the State rankings, States can be grouped according to various measures with some confidence.

In 1999 the NHSDA is being conducted in a computer assisted mode. This technology will make it possible to provide information in the same time frame as the current survey despite the increase in scale and complexity of the new survey. Information from the current survey is available about four months after the field work has been completed. Computer Assisted Self Interviewing (CASI) also will substantially improve the quality and the validity of information provided by respondents. In subsequent years, the survey questionnaire will be modified to improve information on the household, insurance coverage, mental health status, and experience with prevention and treatment programs. Other modifications of the questionnaires and sample will be made in subsequent years to obtain information for assessing Federal substance abuse programs.

Tobacco Module of NHSDA. Beginning in 1999, the tobacco component of the NHSDA will be expanded to permit a more comprehensive set of data on tobacco product use, including information on usual brand. The FY 2000 cost of this addition to the NHSDA is estimated at $4.0 million. This expansion will require lengthening the interview to include more detailed questions. The initiative will increase by 2,500 the number of interviews with youth age 12 to 17, bringing the total sample in this age category to 25,000. This increase in sample size will achieve the desired level of precision. The $4.0 million required for this initiative is to be transferred to SAMHSA by the Department from other sources.

Other OAS Activities. Since the early 1970's, the DAWN survey has been used to identify emerging problems in substance abuse at both the national and local level. Information included in DAWN is obtained from the medical records of individuals admitted to a national sample of hospital emergency departments and from a national sample of medical examiners. The Drug Enforcement Agency uses DAWN data for surveillance and enforcement activities. The pharmaceutical industry uses DAWN to identify problems associated with the use of licit drugs, which were not detected in more limited clinical trials. Changes in the structure of the health care sector will require that the current data collection strategy be evaluated over the next two years.

The Drug and Alcohol Services Information System (DASIS) is the primary source of information on the services available for substance abuse treatment and the characteristics of individuals admitted for treatment. DASIS contains three data sets which have been developed and maintained with the cooperation and

support of the States. The National Facility Register (NFR) lists all treatment facilities in the country which are recognized or approved by the States. A directory developed from the NFR is available in hard copy or online, and is used by public and private health care providers to refer patients to appropriate sources of treatment. Another component of DASIS is the Uniform Facility Data Set (UFDS), which contains detailed information on the characteristics, services, resources, and costs of treatment facilities in the United States. In FY 1997, this data set was expanded to include information on treatment programs in the criminal justice system.

A third component of DASIS is the Treatment Episode Data Set (TEDS), which contains information on every patient admitted to a treatment facility receiving any public funds. TEDS is a relatively new data set but has become a critical source of information on admissions and the treatment process.

In addition, OAS conducts studies evaluating the effectiveness of substance abuse treatment and the validity of the information obtained from providers. The largest of these studies, the Alcohol and Drug Services Survey (ADSS), is directed by a team of investigators at Brandeis University. Among other things, ADSS was designed to describe the changes occurring in the organization and structure of the substance abuse treatment system, and to assess the impact of these changes on the process and effectiveness of treatment.

Center for Substance Abuse Prevention (CSAP)

CSAP will continue to utilize the five-percent set-aside of the twenty percent of the Block Grant designated for prevention for the improvement of State prevention systems. CSAP has utilized the funds to develop and implement advanced prevention methodology for all components of State prevention systems, including systems for data collection and performance measurement. Specific examples of activities to be continued in FY 2000 include:

- State Needs Assessments

CSAP=s State Needs Assessment Program has awarded 3-year contracts to 27 States over the past four years. The purpose of the program is to assist States increase their ability to base their prevention programming, resource allocation, and performance measurement on scientifically sound quantitative data and help improve the States= capacity and infrastructure to conduct studies and utilize data. States receiving contracts are required to conduct a core set of studies, including school-based, archival, and community resource assessments. States may also propose additional studies for funding to determine prevalence and incidence and other factors associated with substance abuse, with particular attention to high risk and special populations such as Native American, the homeless, etc. This information has been invaluable, especially to those States which have received a State Incentive Grant award, as they begin to implement science-based prevention programs to address their critical capacity needs identified through these needs assessments.

- Prevention Technical Assistance (TA) to States

CSAP has provided TA activities to more than 45 States and U.S. jurisdictions to support their substance abuse prevention systems. TA has been provided on-site, by phone, and in multi-State formats. Primary areas of assistance provided include: general TA (addressing prevention system infrastructure); youth tobacco control (helping States to develop tools and strategies to comply with the Synar regulation); minimum data set (promoting common data collection regarding service characteristics and populations served with a set of defined data elements); and State Incentive Grant support. For example, CSAP is developing a computer simulation model designed to assist in the development of comprehensive tobacco control policy. This modeling program, known as SimSmoke, can predict future smoking prevalence rates and smoking-related mortality rates for the entire U.S. population by age, gender, and racial/ethnic group. SimSmoke can also simulate future prevalence and mortality rates in light of two types of policy interventions: price interventions (taxes) and youth access interventions.

CSAP has also provided extensive technical support and training for the directors of substance abuse prevention agencies within the States, with the intention of developing a base set of knowledge and skills within and among the States about the most effective prevention strategies and initiatives.

- Minimum Data Set Program

The CSAP Minimum Data Set (MDS) Program makes an economical, efficient, and user-friendly database management information system (MIS) available to State, sub-State, and local substance abuse prevention agencies and prevention service providers. The common data sets and definitions were developed through a consensus process with State officials and CSAP. The MIS is a PC-based software package for capturing, organizing, and reporting information on the populations served and substance abuse prevention services provided. The MIS is used on a voluntary basis to collect uniform information that informs prevention programming, resource allocation, process evaluation, measuring performance, and data sharing. The MDS Program is also designed to provide the technical assistance, training, documentation, and related services necessary for States to plan for, coordinate, install, and operate the MIS, and use the data gathered. A majority of States are now using or being trained in the MDS system.

CSAP is also planning a more advanced software system. In addition to the core set of services, the more advanced system would include variables for risk and protective factors, intermediate- and long-term performance goals and objectives, and a number of core measures from which States could select. It will have the flexibility of adding and changing outcomes and indicators as requirements change or new knowledge is developed. The system will include decision support capability and a knowledge base to inform and guide State agencies, providers, researchers, and evaluators in carrying out prevention activities.

Center for Substance Abuse Treatment (CSAT)

Currently, CSAT is responding to more than 185 specific requests from State and Territory substance abuse directors for technical assistance that is designed to enhance their jurisdictions' capacity to deliver effective treatment services, or to better manage relevant data in order to monitor outcomes. Some examples of projects funded by CSAT=s allocation of the SAMHSA set-aside are:

C Fourteen State contracts for Treatment Outcomes and Performance Pilot Studies (TOPPS), which address issues needed to improve system capability, standardization, and accountability through better defined and validated measures of substance abuse treatment outcomes and performance measures. New cooperative agreements (TOPPS-II), awarded in September, 1998, will assist States in refining management information systems to systematically monitor common substance abuse treatment effectiveness data measures on both a State and inter-State basis.

C Phase I of the State needs assessment contracts were awarded to 53 states and Territories by the end of 1997, with additional awards initiated to assist all Pacific island jurisdictions in enhancing their data collection, analysis and management capabilities. Some States are now using data generated from the needs assessments for re-direction of State funds and measurement of services impact. States are also using needs assessment findings to guide their initial efforts at introducing and monitoring managed care activities. For example:

< Several States (MI, IL, WA, TX, MN, IO, AZ) are now using findings to inform their States= policy and budgeting development processes as well as to change their resource allocation methodologies and funding patterns. Illinois has used its needs assessment data to develop a new methodology for re-allocating funds among its regions as the Single State Authorities (SSA) develops new contracts with managed care organizations. Arizona, Colorado, North Carolina, and Texas are also using the data for these purposes.

< Iowa has used the findings of its study of alcohol and drug use among women, age 18 and over, to redesign the State=s approach to providing tailored outreach and treatment services for women. The study found that a very low proportion of those needing treatment ever received it (less than 5%), and identified some significant barriers to entering and remaining in treatment. These were: financial concerns, concerns about confidentiality and stigma, and lack of child care.

< New Jersey has used the results from several of its studies to guide the allocation among treatment programs of over $10 million in new funds. New Jersey=s data are also now being used by county level decision makers as they do their annual contracting with providers.

C Phase II of the State Treatment Needs Assessment Program (STNAP) began in 1997 and twenty seven States have received contracts. The second phase will allow repeats of some studies to get trend data as well as to carry out more sophisticated gap analyses. In response to the planned expansion of the

National Household Survey on Drug Abuse (NHSDA) to provide State-level estimates of prevalence, CSAT has been collaborating with ONDCP and OAS to have the National Household Survey on Drug Abuse become the general population survey used by the States in conducting their treatment needs assessments. CSAT anticipates that the NHSDA will replace the individual State adult and adolescent telephone household surveys and school surveys now supported through STNAP.

- Arizona and several other States are conducting a comparison of their findings with NHSDA. The findings will serve as checks on the reliability and validity of the two different interview modalities used. Comparisons are now somewhat more relevant because the NHSDA=s increased sample size makes regional breakouts possible. Texas and several other States have offered to serve as pilots for this approach substituting the NHSDA for their own State telephone household and school surveys to produce prevalence estimates that can be combined with State-conducted special population and social indicator studies to yield relevant small area estimates. States are likely to choose to analyze the NHSDA results only once every 4-5 years, aggregating the yearly samples to ensure a large-enough sample size to do small area estimates and gap analysis.

Other activities, notably collaborative initiatives and training-related projects, which are being supported by CSAT are:

- Collaboration with CMHS and CSAP, the SAMHSA Office of Managed Care and with HCFA in planning training symposia nationwide for all State and mental health directors, and State Medicaid directors, on the use of a guide for substance abuse public purchasers of managed care services: A***Contracting for Managed Substance Abuse and Mental Health Services.***@ The Guide was recently developed and published as TAP # 22 in the CSAT Technical Assistance Publication series.

- The Treatment Improvement Protocols (TIPS) series, which provide state-of-the-art consensus documents on a variety of current topics in the treatment field. To date, 29 TIPS have been published and disseminated to the field. A 4-year evaluation of the TIPS was begun in 1997 to assess their impact on the field.

- State Team Building Workshops on the new Temporary Assistance to Needy Families (TANF) laws. All Single State Authorities (SSAs) and representatives from state welfare offices have attended such conferences, during which they learn from each other and help coordinate the development of their own State plans. The State evaluations of this effort have been exceptional.

Rationale for the Budget Request

A total of $80.8 million will support the continuation and expansion of all activities under the 5% Block Grant set-aside. This amount represents an increase of $1.5 million over the FY 1999 appropriation. All current surveys and studies will be maintained and some improved, as described above.

GPRA Measures of Success

GPRA Goal: This program contributes to the achievement of Goal 4 -- Enhance Service System Performance. This activity will provide information on the following:

1. Estimates of the prevalence of substance abuse at the national level, and in the 50 States and the District of Columbia.

2. Estimates of drug- related emergency department visits at the national level, and for 21 large metropolitan areas.

3. Information on the services available for substance abuse treatment in the United States, and on the characteristics of patients admitted to treatment.
Measure: Increase utility of Federal, State, and local data to enhance service system performance.

F. PROGRAM MANAGEMENT

Authorizing Legislation - Section 301 and Section 501 of the Public Health Service Act

	1998 Actual	1999 Appropriation	2000 Estimate	Increase or Decrease
BA	$55,400,000	$53,400,000	$57,900,000	+$4,500,000
FTE Utilization	549	574	565	- 9

2000 Authorization

PHSA Section 301/501 ..... Indefinite

Purpose and Method of Operation

The Program Management activity includes resources for coordinating, directing, and managing the Agency=s programs. Direct support is provided for each of the three SAMHSA Centers, the Office of the Administrator, the Office of Applied Studies and the Office of Program Services. SAMHSA staff are responsible for managing approximately $2.6 billion in annual program expenditures, including well over 1,000 grant awards and 200 major contracts. In fiscal year 1999, SAMHSA implemented several new programs, including the Mental Health Violence in Schools Initiative and HIV/AIDS grants in minority communities. New Targeted Capacity Expansion activities were also initiated. At the same time, SAMHSA continues to place increased emphasis on outcome measurement and program accountability. These activities, as well as increased reliance on cooperative agreement funding mechanisms, require more intensive staff involvement in data collection and evaluation.

Funding and staffing levels for the past five fiscal years were as follows:

	Funding	FTE
1995	$61,113,000	591
1996	56,118,000	587
1997	55,331,000	552
1998	55,400,000	549
1999	53,400,000	574

Rationale for the Budget Request

The FY 2000 budget requests an increase of $4.5 million to cover necessary (mandatory) cost increases anticipated that year, including pay raises, rent, and overhead charges. No program increases are

requested. This funding level assumes that nine fewer FTEs can be supported than in FY 1999, and the lower operating level will be achieved through attrition.

The increased program workload evident in both 1999 and 2000 will be addressed through continuing management efficiencies. Program reviews will be conducted to redirect staff internally to new, expanding, or higher priority program areas. Quality of worklife actions will help increase effectiveness and collaboration on crosscutting programs and areas of interest. SAMHSA will continue to strengthen its policies to help employees balance work and family responsibilities.

All automated SAMHSA information systems have been adjusted, if necessary, to be Year 2000 compliant. Four of the five mission critical systems have been independently validated as Y2K compliant, with the final one to be completed by March, 1999. No additional resources are necessary for this purpose.

The FY 2000 budget for HHS also includes a physician compensation payroll policy of 6 percent growth per year. In effect, the policy guideline means that physician payroll in HHS would beheld to 6 percent annual growth in FY 2000 and future years.

Full-Time Equivalent (FTE) Employment

	FY 1998 Actual	FY 1999 Estimate	FY 2000 Estimate	Increase or Decrease
FTEs:				
Direct	504	529	520	- 9
Reimbursable	6	6	6	---
Block Grant Set-Aside	3939	39	---	
Total	549	574	565	- 9

Increases:

Built-in:

Annualization of 1999 pay costs	+$1,137,000
Within grade pay increases	+837,000
Increase for January 2000 pay raise at 4.4%	+1,528,000
Increase in rental payments to GSA	+229,000
Increase for overhead charges	+769,000
Total, Increases	+$4,500,000
Net Change	+$4,500,000

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
DRUG ABUSE BUDGET

I. RESOURCE SUMMARY

II. METHODOLOGY

C Funding for SAMHSA=s Substance Abuse Prevention and Treatment Knowledge Development

(Budget Authority in Millions)

	1998 Actual	1999 Enacted	2000 Request
Drug Resources by Goal			
Goal 1	$402.987	$441.192	$423.959
Goal 2	11.660	10.600	---
Goal 3	905.372	1,032.716	1,112.739
Total	$1,320.019	$1,484.508	$1,536.698
Drug Resources by Function			
Prevention	$402.987	$441.192	$423.959
Treatment	917.032	1,043.316	1,112.739
Total	$1,320.019	$1,484.508	$1,536.698
Drug Resources by Decision Unit			
Knowledge Development and Application Program	215.457	195.353	169.353
Substance Abuse Prevention (Non-add)	*(84.321)*	*(78.717)*	*(52.717)*
Substance Abuse Treatment (Non-add)	*(131.136)*	*(116.636)*	*(116.636)*
Targeted Capacity Expansion Program	91.411	133.515	188.515
Substance Abuse Prevention (Non-add)	*(66.679)*	*(78.283)*	*(78.283)*
Substance Abuse Treatment (Non-add)	*(24.732)*	*(55.232)*	*(110.232)*
High Risk Youth Program	6.000	7.000	7.000
National Data Collection	18.000	---	---
Substance Abuse Block Grant (SAPTBG)	965.900	1,126.460	1,147.781
Program Management	23.251	22.180	24.049
Total	$1,320.019	$1,484.508	$1,536.698
Drug Only Funding (Non-add)	*($1,066.925)*	*($1,190.173)*	*($1,236.792)*
Alcohol Primary/Drug Secondary -- SAPTBG (Non-add)	*(194.190)*	*(225.863)*	*(230.138)*
Alcohol Under Age 21 -- SAPTBG (Non-add)	*(58.904)*	*(68.472)*	*(69.768)*
Total Drug Abuse, Including Alcohol-Related (Non-add)	*($1,320.019)*	*($1,484.508)*	*($1,536.698)*
Drug Resources Personnel Summary			
Total FTEs	307	306	306
Information			
Total Agency Budget	$2,198.056	$2,488.005	$2,626.505
Drug Percentage	60.05%	59.67%	58.51%

and Application (KDA) activities and funding for OAS data collection activities are considered to be 100 percent drug-related.

- Funding for SAMHSA=s Substance Abuse Prevention and Treatment Targeted Capacity Expansion (TCE) activities are considered to be 100 percent drug-related.

- Funding for SAMHSA=s substance abuse prevention High Risk Youth (HRY) program is considered to be 100 percent drug-related.

- Funding for the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) is considered drug-related to the extent that these funds are used by the States/Territories for treatment and prevention of the use of illegal drugs and used by the Agency for technical assistance, data collection, and program evaluation. SAMHSA has continued to use the methodology in estimating drug related activities consistent with the earmarks required by P.L. 102-321.

- Five percent of the block grant is required to be used for set-aside activities which support data collection, technical assistance, the National Data Center, and program evaluation. The remaining 95 percent is distributed to the States and Territories where at least: 35 percent must be used for alcohol prevention and treatment activities; 35 percent must be used for other drug prevention and treatment activities; and, the remaining 30 percent is to be used at State discretion, either for alcohol alone, for drugs alone, or shared by both alcohol and drug programs. For budget formulation purposes, SAMHSA and ONDCP agreed to score the discretionary amount equally for alcohol and drugs, with 15 percent assigned to alcohol programs and 15 percent assigned to drug programs.

- Funding for Program Management activities is considered drug-related to the extent that funds are used to support the operations of the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the activities of the Office of Applied Studies (OAS) that are supported by set-aside funds from the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

III. PROGRAM SUMMARY

Goal 1: Educate and enable America=s youth to reject illegal drugs as well as alcohol and tobacco.

- Financial support for this goal includes funding for prevention Knowledge Development and Application (KDA) programs, prevention Targeted Capacity Expansion (TCE) programs, workplace programs (administered by CSAP), the High Risk Youth Program, data collection activities (administered by OAS), and 20% of the Substance Abuse Prevention and Treatment Block Grant, as well as program support for these activities.

- Funding for prevention KDA programs supports defined population studies to field test controlled study findings under varying real-world conditions and with diverse populations. Prevention programs involve developing and assessing new and emerging prevention methodologies and approaches; collecting, analyzing, and synthesizing prevention outcome knowledge, and monitoring national trends in substance abuse and emerging issues. Knowledge development programs develop knowledge about prevention strategies effective across the life-span, with specific programs targeting early childhood, children and their families, adults, and the elderly. After field testing promising approaches in knowledge development programs, emphasis shifts to the synthesis and dissemination of the knowledge gained from these final study phases to the practical application of these strategies by States and local communities. Knowledge application programs help substance abuse prevention practitioners and policy makers in States and communities systematically deliver and apply skills, techniques, models, and approaches to improve substance abuse prevention services. In the aggregate, CSAP=s knowledge application programs complete the research to practice continuum by synthesizing and translating scientific findings into useable knowledge, programs and packages, disseminating that knowledge widely, and helping States, communities and individuals to adopt and use it to meet local needs.

- The Federal Drug Free Workplace (DFWP) and National Laboratory Certification (NLCP) Programs reduce adult substance abuse demand in the Federal service and promulgate scientific and technical guidelines for Federal employee drug testing programs. NLCP certifies drug testing laboratories, provides guidance for self-sustaining drug testing programs, and is the Federal focal point for developing and implementing non-military, Federal workplace drug testing technical, administrative and quality assurance programs.

- Funding for prevention Targeted Capacity Expansion (TCE) programs supports efforts designed to address the specific and immediate prevention service capacity needs within the States and communities. TCE programs represent a comprehensive effort to improve the quality and availability of effective research-based prevention services and to help States and communities address and close gaps in prevention services which often cannot be addressed via the block grant funding process. With primary foci on improving capacity and fostering the use of current Abest practices@ in actual service systems, these programs assure the consistency and nature of services delivered and enable the collection of client outcome data--characteristics not available in Federal block-grant supported services. TCE provides a mechanism to support limited, but targeted, services in discrete areas of unmet or emerging local needs made apparent from epidemiological data, from local experience, or created as a result of local, State or national social policy change.

- Funding for High Risk Youth (HRY) supports testing of a wide variety of interventions to prevent substance abuse among children and youth. Building on projects that have been comprehensive and

have focused on the major domains--individual, family, school, peers, community -- which impact the life of a child and based on knowledge gained from CSAP and other research efforts, a new program targeting high-risk youth was initiated in FY 1998. This program focuses, in particular, on youth who are at high risk for becoming substance abusers and/or involved in the juvenile justice system. Specifically, the new HRY - Project Youth Connect program targets youth ages 9-11, and those ages 12-18, and seeks to intervene with these youth while they are at a period in their lives when positive influences can still have an effect. Mentoring as a substance abuse prevention strategy is featured in this program.

< SAPTBG activities include State expenditures of 20% of their block grant allotment for prevention services as well as 20% of the Block Grant set-aside for the collection and analysis of national data, the development of State data systems (including the development and maintenance of baseline data on the incidence and prevalence as well as the development of outcome measures on the effectiveness of prevention programs), provision of technical assistance, and program evaluations. Also, this program supports oversight of Synar Amendment implementation requiring States to enact and enforce laws prohibiting the sale and distribution of tobacco products to persons under 18 so as to reduce the availability of tobacco products to minors.

Goal 2: Increase the safety of America=s citizens by substantially reducing drug-related crime and violence.

C Financial support for this goal includes criminal justice-related treatment funding from the treatment Knowledge Development and Application program (KDA), as well as program support for these activities. Funding for treatment KDA programs includes continuation of pre-1996 demonstration awards for criminal justice programs (adult, juvenile, institutional, and community based). The authorities for these programs have expired. The remainder of the treatment KDA portfolio, to include those projects in support of treatment in the criminal justice system, are found in CSAT knowledge development and application programs (KDA).

Goal 3: Reduce health and social costs to the public of illegal drug use.

C Financial support for this goal includes funding for treatment Knowledge Development and Application programs (KDA), Targeted Treatment Capacity Expansion (TCE) programs, and 80% of the Substance Abuse Prevention and Treatment Block Grant, as well as program support for these activities.

< Funding for treatment KDA programs includes continuation of pre-1996 demonstration awards including funding for the Target Cities program, women and children programs (Pregnant and Postpartum Women, Residential Treatment for Women and Children), Critical Population programs, AIDS program (linkage, outreach), and training programs. The authorities for these

programs have expired. The remainder of the treatment KDA portfolio includes knowledge development and application activities to: bridge the gap between knowledge and practice; promote the adoption of best practices; and assure services availability/meet targeted needs.

< Targeted Treatment Capacity Expansion (TCE) programs have been established to focus more funding toward decreasing the substance abuse treatment gap. Initially, treatment TCE activities were funded as part of the treatment KDA program, but in the year 2000, Targeted Capacity Expansion programs have been approved as a separate line item in the SAMHSA budget. The Targeted Treatment Capacity Expansion program is designed to address gaps in treatment capacity by supporting rapid and strategic responses to demand for alcohol and drug abuse treatment services. The response to treatment capacity problems may include communities with serious, emerging drug problems or communities struggling with unmet need. In 1999, these programs will include an HIV/AIDS component targeting minority populations at risk of contracting HIV/AIDS or living with HIV/AIDS. The goal of this aspect of the TCE program will be to enhance and improve existing substance abuse treatment services for minority populations in cities and States highly impacted by the twin epidemics of substance abuse and HIV/AIDS.

< SAPTBG activities include State expenditures of 80% of their block grant allotment for treatment services as well as CSAT and OAS expenditures of 80% of the Block Grant set-aside for the collection and analysis of national data, the development of State data systems (including the development and maintenance of baseline data on the incidence and prevalence as well as the development of outcome measures on the effectiveness of treatment programs), provision of technical assistance, and program evaluations.

IV. BUDGET SUMMARY

1999 Program

C The total drug control budget supported by the 1999 appropriation is $1.485 billion, including $.441 billion for Goal 1, $10.6 million for Goal 2, and $1.033 billion for Goal 3.

Goal 1: Educate and enable America=s youth to reject illegal drugs as well as the use of alcohol and tobacco.

C A total of $265.1 million (including $43.3 million in set-aside funding for SAMHSA=s Office of Applied Studies) is available for Goal 1 substance abuse prevention activities from the SAPTBG. Activities funded through the Block Grant prevention funds include:

< State expenditures of a minimum of 20% of their block grant allotment for primary prevention, as well as CSAP expenditures of 20% of the block grant set-aside for the development of State data

systems (including the development and maintenance of baseline data on incidence and prevalence as well as the development and implementation of outcome measures on the effectiveness of prevention programs), provision of technical assistance, and program evaluations. Funds also support facilitating and monitoring States= compliance with the Synar Amendment that is designed to reduce accessibility of tobacco to minors.

< Increased 1999 funding for this program should help minimize the loss of revenues to individual States from the use of the new wage proxy as well as increase national treatment capacity and support national data collection activities.

C A total of $78.7 million is available for Goal 1 Knowledge Development and Application activities including funding for the following:

< **Starting Early Starting Smart** which is generating new empirical knowledge about the effectiveness of integrating substance abuse prevention, substance abuse treatment and mental health services for children ages zero to seven who experience multiple risk factors for substance abuse or mental health problems. Importantly, projects are measuring processes being used to provide integrated services in order to understand the role played by specific service designs in program success using a common research design and data collection methodologies.

< **Developmental Predictor Variables 10-Site Study** which is developing and evaluating prevention interventions identified in NIH controlled studies within four age cohorts starting at age three, following each age cohort for two years, and then linking the cohorts together to capture the developmental range from 3- to 14-years of age. This program is also testing the effectiveness of strategies tailored for children living in urban and rural areas.

< **Community Initiated Prevention Interventions** program which supports field-initiated projects that test or replicate research-based substance abuse prevention interventions having high potential for preventing, delaying, or reducing alcohol, tobacco, or illicit drug use among high risk populations. Under this program, interventions such as family mentoring/support, school violence/school climate change interventions, and life transitioning interventions and vulnerable populations such as persons with physical or mental disorders, Native American and immigrant children, and persons living in rural areas are among the many possible focus areas.

< **Parenting Adolescents** program, is building the knowledge base about the effects of welfare reform on parenting teens and measuring the effects of preventive interventions tailored to this population. The program is helping parenting teens resist substance abuse, improve academic achievement and complete school, avoid repeat pregnancies, and improve their life- and parenting-skills, as well as their health and well-being.

- **Children of Substance-Abusing Parents (COSAPS)** which is generating knowledge about the most effective prevention models and associated services for enhancing protective factors and minimizing risk factors for developing substance abuse and/or other behavioral, emotional, social, cognitive and physical problems as a result of their parents= substance abuse. Projects are implementing, refining, and adapting established and effective scientifically defensible prevention intervention programs for this vulnerable population to assess their effectiveness in local community settings.

- **Alcohol Research** programs to determine whether alcohol advertising affects the initiation of drinking among youth, and whether alcohol advertising affects their consumption patterns and to identify, test, and/or develop effective interventions to prevent and reduce alcohol-related problems among college students. .

- **National Strengthening the Family Initiative** which includes a dissemination research program that is determining cost effective methods for disseminating information and training on science-based family-focused prevention strategies and demonstrated effective models in order to extend the application of these models to multiple communities across the country. The Initiative also includes the Parenting is Prevention Program to strengthen existing anti-drug programs directed by parents, to assist in developing a drug focus for various parent groups that do not currently have a major drug focus, and to provide training, technical assistance and resources for parents in initiating drug prevention programs for youth.

- **Workplace Programs** which engage the business community and the private and public sectors with both drug testing and drug free workplaces. Working with other Federal agencies, States, the business community, labor organizations, and national organizations, the **Federal Drug Free Workplace (DFWP)** and **National Laboratory Certification (NLCP) Programs** are reducing adult substance abuse demand in the Federal service and developing and implementing non-military, Federal workplace drug testing related technical, administrative and quality assurance programs. NLCP certified laboratories impact about 8 million Federal and federally regulated industry employees annually . In FY 1999, the last year of this program, the **Workplace Managed Care Substance Abuse Prevention and Early Intervention Program** will continue to assess the impact of substance abuse prevention and early intervention within managed care programs at the worksite to determine which are most effective and at what costs and to disseminate and apply positive results.

- **Prevention Enhancement Protocol System (PEPS)** which is collecting, synthesizing and translating and disseminating research- and practice-based findings in useable form for application in communities. PEPS is a pioneering initiative that develops program and intervention guidelines for the field using established Arules of evidence@ for assessing practice and research findings and combining this evidence into prevention approaches.

< **National Center for the Advancement of Prevention - II (NCAP II)** is developing, synthesizing, updating, adapting and disseminating state-of-the-art prevention knowledge about what works in prevention, for whom, and under what conditions. NCAP II makes knowledge-based tools, principles and models useful for developing prevention plans and programs available to States, communities, and local prevention practitioners and policy makers to improve the effectiveness of prevention efforts across the nation.

< **Faculty Development Program (FDP**) which is continuing to develop a cadre of physicians and other health professionals with an expertise in teaching and advocating for substance abuse prevention. The interdisciplinary training that FDP fellows receive uniquely prepares them to provide the integrated health services necessary to meet the population based challenges facing the American public. This program, through its penetration into Schools of Medicine, Social Work, Psychiatry, and Public Health, will significantly impact managed health care executives in the future.

< **National Clearinghouse for Alcohol and Drug Information** which continues to answer inquiries generated by the ONDCP National Anti-Drug Media Campaign in addition to responding to thousands of public requests for information about causes, consequences, and effective strategies used to address substance abuse and its related problems.

< **Public education/ mass media efforts** including support for ONDCP=s *Anti-Drug Media Campaign*; a media campaign entitled *Your Time - Their Future* that is highlighting the importance of positive skill-building activities in preventing and reducing substance abuse among youth ages 7-14; a campaign entitled *Alcohol: We=re Not Buying It* that targets alcohol use among underage youth and a campaign targeting Hispanic girls modeled after the A*Girl Power!*@ media campaign to deliver tailored and culturally-relevant Ano use@ messages about tobacco, alcohol, and illicit drugs with an emphasis on providing skill- and confidence-building opportunities to help Spanish-speaking girls ages 9-14 make the most of their lives.

C A total of $78.3 million is available for Goal 1 prevention Targeted Capacity Expansion activities including funding for the following:

< **State Incentive Grant (SIG) Program** which extends CSAP=s ability to help States to improve their prevention service capacity. Funding will enable States to examine their State prevention systems and redirect State resources to critical targeted prevention service needs within their states. Eighty-five percent of SIG funds are directed toward implementing best practices within local programming to reduce the gap in prevention services. In this way SIG funds not only help improve access to needed services, they also improve the quality of the prevention services provided. SIG States will also continue to field test their core measures to assess their feasibility for use in reporting on block grant activities, to create Statewide networks of public and private organizations to extend

the reach of the primary prevention portion of the SAPT Block Grant and optimize the application of State and Federal substance abuse funding streams.

< **Centers for the Application of Prevention Technologies (CAPTS)** in five regions and at the U.S.-Mexico Border provide support to the SIGs, other States and their communities by transferring research-based knowledge and delivering tailored technical assistance, training, and supportive materials to meet the unique needs of communities and States in their respective geographical areas.

< **Services to Address HIV/AIDS and Substance Abuse Among African American and Hispanic Youth and Women.** This TCE program supports establishment of a Substance Abuse and HIV Prevention Consortium to enable provision of policy advice and consultation on issues related to improving SA/HIV prevention services to these specific population groups; supplements to CSAP=s six Centers for the Application of Prevention Technologies to enable integration of HIV prevention into their substance abuse prevention materials and curricula; expanding the focus of training and TA for community based organizations and consortia; and a program to initiate or strengthen the integration of HIV and substance abuse prevention at the local level and increasing local capacity to provide integrated services to African American and Hispanic youth and women.

In addition, CSAP=s Youth and Women of Color Initiative continues to identify specific interventions tailored for youth and women of color at risk for substance abuse and HIV disease and to develop strategies with emphasis on reducing known risk factors, increasing protective factors, building resiliency, and addressing multiple risks that cross domains.

C A total of $7.0 million is available for Goal 1 High Risk Youth as follows:

< **High Risk Youth: Project Youth Connect** which is determining if an intensive mentoring/advocacy prevention intervention model and associated services are effective in preventing, reducing, or delaying the onset of substance abuse, improving school bonding and academic performance, improving family and bonding and family relationships and improving life management skills among children ages 9-15 and their families.

Goal 2: Increase the safety of America=s citizens by substantially reducing drug-related crime and violence.

C A total of $10.6 million is available for Goal 2 Knowledge Development and Application activities including funding for the following:

< **Criminal Justice Treatment Networks, Criminal Justice Diversion and Drug Court Activities.** The **Criminal Justice Diversion** study will identify methods for diverting individuals with substance abuse disorders from the criminal justice system to community treatment alternatives.

It will assess the following outcomes: criminal recidivism, time incarcerated, continuity of participation in treatment, emergency treatment utilization, and reduction of frequency of substance abuse.

Goal 3: Reduce health and social costs to the public of illegal drug use.

C A total of $1.585 billion is available for the SAPTBG in 1999. Approximately 71 percent of this total, or $1.126 billion, is related to drug abuse activities:

< The treatment gap is growing. Our latest estimate projects that a total of 3.6 million persons with severe problems did not receive treatment in 1997. This represents a 37% increase in the gap since 1994 and itself would require approximately $8 billion to totally bridge the gap with direct Federal funds. The Administration does not propose to bridge this gap entirely with direct funding but rather with significant infusions of Federal funds to leverage State, local, third party and other resources to grow effective systems of care. Grants will continue to be used to encourage States, cities, and/or other government entities to adopt effective service strategies and to leverage block grant and other resources to Agrow@ local, regional and statewide systems in conjunction with increased funding proposed for the block grant program. We will continue to provide estimates of the treatment gap each year to ONDCP and will be monitoring the progress of our grant recipients and the nation in total in bridging this gap on a national, state and local basis.

< **Treatment Outcomes and Performance Pilot Studies (TOPPS II)** will assist States in refining management information systems to systematically monitor common substance abuse treatment effectiveness data measures on both a State and inter-State basis.

C A total of $116.6 million is available for Goal 3 Knowledge Development and Application drug-related activities in 1999, including funding for the following activities:

< Continuation of existing treatment programs that will reach their final award year in 1999 or later, such as: **Pregnant and Post-Partum Women Programs; Residential Treatment Program for Women and Children;** and the **Rural, Remote, and Culturally Distinct Programs.**

< The **Addiction Technology Transfer Centers** which will transfer technology from science to practice through knowledge development, dissemination, and application, incorporating such things as needs assessment, multi-disciplinary linkages, curricula development, and other special initiatives.

< The **Identification of Exemplary Treatment Models** which creates a partnership between States, communities and the Federal government to explore the development of knowledge and its application in the development of effective treatment approaches for replication.

< **Special Drug Studies (Alcohol, Methamphetamine and Marijuana).** The *Treatment for Adolescent Alcohol Abuse and Alcoholism* program will contribute to the identification and development of efficacious treatment interventions for adolescent alcohol abusers and alcoholics. CSAT supports a study examining the *Effectiveness of Treatment for Marijuana Dependent Youth,* and will evaluate a variety of treatment interventions for adolescents. The *Replicating Effective Treatment for Methamphetamine Dependence* study will contribute to the development of knowledge of psychosocial treatment of methamphetamine dependence as well as providing an opportunity to determine the problems involved in technology transfer.

< The **Persistent Effects of Treatment Study** which will evaluate the long-term effectiveness of substance abuse treatment services through a series of grants and cooperative agreements and conduct a number of special studies and policy analyses that address specific drugs of abuse, methods of treatment, populations or policy issues. Wide dissemination will be made through technical reports, professional journals and conferences.

< **Recovery Community Support Program (RCSP)** grants to State, provider, and community-based organizations for enhancing substance abuse treatment programs. These programs are intended to give persons in recovery a stronger voice in substance abuse services policy and planning at the state and local levels. It will involve persons with co-existing disorders, as well as their families, in the design and evaluation of substance abuse treatment services. A major focus will be to identify barriers to treatment in local settings, as well as to recommend ways to overcome or reduce them.

C A total of $55.2 million is available for Goal 3 Targeted Treatment Capacity Expansion activities in 1999, including funding for the following:

< Continuation of 41 **Targeted Treatment Capacity Expansion** grants awarded in 1998 which support States, cities, and/or other government entities in creation and expansion of comprehensive substance abuse treatment services, promoting accountability and enhancing the quality of and access to treatment services. This will include efforts to identify gaps in the substance abuse service delivery system, and where current capacity within a treatment modality is insufficient, provide for expanded access to treatment. Funds provided by this program will also serve as support for States and communities to more effectively coordinate Federal, State and local resources directed at providing substance abuse treatment and ancillary services. A comprehensive service system will be developed aimed at providing a clinically appropriate range of services, reducing service gaps and reducing drug use and abuse by under-served populations. Award of new grants in 1999 will include $16 million for targeted minority populations at risk of contracting HIV/AIDS or living with HIV/AIDS.

FY 2000 Request

C A total of $1.537 billion is requested for the drug abuse budget, representing a net $52.2 million increase over the prior year. This reflects an increase of $55 million for Targeted Treatment Capacity Expansion, an increase of $21.3 million in the drug abuse-related portion of the Substance Abuse Prevention and Treatment Block Grant, and an increase of $1.9 million in drug abuse program management funding. These increases, however, are partially offset by a reduction of $26 million in the substance abuse prevention KDA discretionary grant and contract funding. Requested treatment funding increases for 2000 are expected to result in treatment services being provided to approximately 19,700 additional persons over 1999, for a total of almost 404,000 persons served with direct Federal funding.

Goal 1: Educate and enable America=s youth to reject illegal drugs as well as alcohol and tobacco.

C CSAP proposes the following new initiatives/program expansions in support of Goal 1 in FY 2000:

< The 20% prevention set-aside of the **Substance Abuse Prevention and Treatment Block Grant** is increased by $4.3 million over FY 1999 levels providing resources for States to support additional primary prevention services at the local level.

< $12 million of the funds available in FY 2000 will be used to support four new **State Incentive Grants**. Funding will enable States to examining their State prevention systems and redirecting State resources to critical targeted prevention service needs within their states. This expansion is consistent with the Office of National Drug Control Policy language calling for a SIG grant in every State by the year 2003. This will bring the SIG program to approximately 25 of the 60 States and Territories by FY 2000.

< CSAP will also contribute to the SAMHSA crosscutting initiatives on Underage Drinking and Women with Histories of Violence. CSAP will have the lead in the **National Agenda Against Underage Drinking** for the prevention aspects of the knowledge development and knowledge application components of this initiative and will work with States to develop/strengthen coalitions of stakeholders, develop and implement regional plans, and convene heads of all public institutions of higher learning to apply best practices to reduce binge drinking among youth ages 18 to 21. **Violence Against Women** is a new cross-cutting initiative that seeks to promote the improved coordination of services to women and their families affected by violence. CSAP will work with CSAT and CMHS to provide cross training for service providers from diverse backgrounds and communicate information regarding new service approaches and improving service delivery systems.

Goal 2: Increase the safety of America=s citizens by substantially reducing drug-related crime and violence.

C There are no proposed new initiatives in support of Goal 2 for FY 2000.

Goal 3: Reduce health and social costs to the public of illegal drug use.

C No new prevention TCE or KDA programs are proposed under this goal for FY 2000.

C CSAT proposes the following new initiatives/program expansion in support of Goal 3 in FY 2000:

< **Targeted Treatment Capacity Expansion ($55 million):** Only 2.1 million out of the 5.7 million persons who use and abuse alcohol and other drugs (Level II treatment need) can be served through existing publicly funded treatment systems. The goal of this program is to create or expand the ability to provide an integrated creative and community-based response to a targeted, well-documented substance abuse treatment capacity problem. This program proposes to award new grants in FY 2000 to continue reduction of the treatment gap. It does not specify any earmarks for big or little states, counties or cities. Another major emphasis of the Targeted Treatment Capacity Expansion funds, begun in FY 1999 and planned for continuation and expansion in FY 2000, is the provision of treatment services for targeted minority populations at risk of contracting HIV/AIDS or living with HIV/AIDS. These include substance abusing African American and Hispanic women and their children; substance abusing African American and Hispanic adolescent boys and girls; and substance abusing African American and Hispanic men. The overall goal of this program is to enhance and improve existing substance abuse treatment services for these populations in cities and States highly impacted by the twin epidemics of substance abuse and HIV/AIDS.

< **Substance Abuse Prevention and Treatment Block Grant ($30 million):** An increase of $30 million is requested for the Block Grant, for a total of $1.615 billion in 2000. Of the total requested amount, $1.148 billion would be scored for drug abuse prevention and treatment activities. Of the proposed $30 million increase, $21.3 million is drug-related, and 80% of this amount, or $17.1 million, would support State treatment initiatives. This formula-driven grant is the cornerstone of the States= substance abuse programs, accounting for approximately 40% of public funds expended for treatment and prevention (1995). In 19 States (1997), the block grant provided the majority of funding available to support substance abuse treatment services.

< **Underage Drinking Initiative (KDA):** CSAT=s primary role in the **National Agenda Against Underage Drinking** will be related to the generation of new empirical knowledge about what brief intervention and treatment models and associated services are most effective for brief intervention or treatment of alcohol use, misuse, and abuse in the cited underage populations.

< **Violence Against Women Initiative (KDA):** The activities included in this initiative will build on SAMHSA=s previous gender specific treatment efforts with women. This initiative seeks to discover what works to improve women=s outcomes in the utilization of substance abuse treatment services and to promote the improved coordination of services by developing an integrated services approach to organizing and institutionalizing coordinated social service delivery systems. The initiative will assess outcome, effectiveness and cost-effectiveness of the integrated service delivery systems. The initiative will also apply what is known to enhance and evaluate the effectiveness of treatment service delivery systems for women, specifically targeting underserved populations with addictive disorders. It will primarily focus on several diverse racial/ethnic populations, including African Americans, Latinos/Hispanics, American Indian/Alaska Natives, and Asian American/Pacific Islanders, as well as include a component to address immigrants, women with disabilities, and other special populations.

V. PROGRAM ACCOMPLISHMENTS

C CSAP=s first Knowledge Development study, the **Developmental Predictor Variable 10-site Cross-site Study** is only 21 months old, yet it has already generated statistically significant positive outcomes with all sites using the same core process and outcome instruments. Investigators in Utah, Georgia, North Carolina and Washington report decreases in family conflict, aggression, conduct disorders, improved cooperation and academic performance, and decreases in substance use as a result of program interventions. As an example, the *Coping Power: Kids and Parents Program* reported significant reductions in teacher=s ratings of aggression (a major precursor of drug use) in 9-10 year old African-American and white students.

C CSAP=s **High Risk Grantee Cross-site Study** has gleaned new knowledge on the major precursors of drug use in a large sample of youth, confirming a variant of the Social Ecology Model of Adolescent Substance Abuse and providing new data on the most powerful pathway to drug use: 1) poor family relationships, leading to 2) poor family supervision and discipline, and 3) family norms conducive to drug use. Detailed information on these program findings has been published in CSAP=s AUnderstanding Substance Abuse Prevention - Toward the 21st Century: A Primer on Effective Programs.@

C The **Prevention Enhancement Protocol System (PEPS)** is a CSAP initiative to develop evidence-based program planning and intervention guidelines for the field of substance abuse prevention. To date, two PEPS guides have been published: Reducing Tobacco Use Among Youth: Community-Based Approaches and Reducing Substance Abuse and Children and Adolescents: family-based Approaches. Two additional PEPS guides are nearing completion: Reducing Problems Related to Retail Alcohol Availability: Environmental Approaches; and Mass Media: Approaches to Substance Abuse Prevention. A fifth PEPS guideline, School-Based

Strategies for Substance Abuse Prevention, is being developed in conjunction with the U.S. Department of Education=s Drug-free Schools Program.

C **Tobacco Control Efforts/Synar Implementation**. All 51 States, including the District of Columbia, are in material compliance with the Synar Regulation. They have laws prohibiting the sale or distribution of tobacco to minors, and they are enforcing those laws. The median noncompliance rate of sales to minors as reported by the States in 1998 was 24.4 percent. This is a significant reduction from the median rate of 40 percent reported in 1997 and pre-1997 studies that found noncompliance rates ranging from 60 to 90 percent.

C **Core Data** -- Discussions with the five SIG grantees over the past year have resulted in a mutual agreement as to the need for States to collect data in common to improve accountability for their use of block grant funds. SIG states have agreed to collect core data at the State, substate and program levels. Variables and instruments have already been identified for use. This practice will not only yield impressive data concerning the process and outcomes of the SIG activities, States are also using these data to field test the feasibility of using these measures as we move towards the implementation of performance partnership grants.

C In September 1998, CSAT awarded 41 **Targeted Treatment Capacity Expansion** grants to municipal, county, State, tribal governments, and their respective service providers to help close the gap in treatment for emerging substance abuse problems in 22 States. The grantees will provide services for substance abusing women and their children, clients participating in welfare reform programs, juvenile and adult criminal justice-referred offenders, dually diagnosed offenders, substance abusing physically and cognitively challenged individuals, and hard-to-reach intravenous drug users. The program supports the cultivation of a substance abuse treatment system that is responsive to emerging trends.

C In 1998, CSAT convened four State team building meetings that brought together key stakeholders from each State responsible for implementation of the **Welfare-to-Work** initiatives and substance abuse treatment. Approximately one-third of the stakeholders reported that these State team building meetings brought many of these individuals together for the first time. As a result of these interactions, States have reported outcomes such as the designation of the Department of Labor=s welfare-to-work funds administered by the Private Industry Councils for substance abuse treatment services, work training services for persons recovering from addiction, the implementation of cooperative efforts to provide appropriate substance abuse screening of welfare recipients and the enhancement of vocational services within substance abuse treatment programs.

C The **Identification of Exemplary Adolescent Treatment Models** is designed to identify those regimens of care that appear to be exemplary and may be useful for further replication and dissemination. The major focus of the five projects funded in 1998 is to evaluate and measure the

level of success in terms of client outcomes and effectiveness. A special emphasis in some of the sites will be on treatment of adolescent heroin abusers.

C In 1998, CSAT awarded nineteen new **Recovery Community Support Program (RCSP)** grants to State, provider, and community-based organizations for enhancing substance abuse treatment to programs in 15 States. These programs are intended to give persons in recovery a stronger voice in substance abuse services policy and planning at the state and local levels. One of these programs, *ACCESS NOW! Recovery Community Alliance Project*, in Tucson, Arizona, is focusing its efforts specifically on members of the recovery community who also have concomitant cognitive and/or physical disabilities. RCSP projects involve persons with co-existing disorders, as well as their families, in the design and evaluation of substance abuse treatment services. A major challenge is to identify barriers to treatment in local settings, as well as to recommend ways to overcome or reduce them.

C The **National Spending Estimates for Substance Abuse Treatment** study was released in 1998. The first such study published by CSAT, it estimates substance abuse treatment expenditures adapting data and methods that the Health Care Financing Administration (HCFA) uses for estimates of national health expenditures. Consequently, the estimates for substance abuse are comparable to those produced by HCFA for health care. This study is expected to produce such estimates on an annual basis for the foreseeable future. Tracking treatment expenditures is essential for understanding the effect of the dynamic changes occurring in the health care industry. When linked with prevalence and utilization data, information about expenditures can also be used to better describe health care patterns.

C The **Treatment Improvement Protocols (TIP) Series** provide state-of-the-art, consensus-based treatment protocols. In 1998, five more TIPs were published by CSAT: 1) Guide to Substance Abuse Services for Primary Care Clinicians; 2) Substance Abuse Treatment and Domestic Violence; 3) Substance Abuse Among Older Adults; 4) Comprehensive Case Management for Substance Abuse Treatment; and, 5) Naltrexone and Alcoholism Treatment.

VI. PROGRAM STATISTICS

C Resource Summary - Detail by Goal and Functions (See Table)

$ Treatment Gap (See Table)

C Persons Served (See Table)

	Program Title	Drug Related Percent	FY 1998 Actual
Drug Resources by Goals and Functions			
Goal 1			
Impact Target a	YSAPI (Reduce Youth Past Mo Prevalence)	100.00	70.30
OAS/National Data Collection	National Household Survey on Drug Abuse	100.00	18.00
Objective 1	SAPT Block Grant Set-aside *	100.00	13.10
1. Adult Understanding and capacity.	NCADI	100.00	5.40
2. Adults influencing youth.	Strengthening Family Program	100.00	
Subtotal			106.80
Objective 3	Block Grant Prevention Portion	71.07	175.08
1. Zero tolerance in schools.			
2. Zero tolerance in communities.			
Subtotal			175.08
Objective 5			
1. Develop mentoring program.	High Risk Youth: Mentor Program	100.00	6.00
2. Implement mentoring program.			
Subtotal			6.00
Objective 6			
1. Develop coalition directory.			
2. Funded coalitions.	Community Partnerships	100.00	9.50
Subtotal			9.50
Objective 7			
1. Partnerships.	Materials Development/Media Literacy	100.00	2.00
Subtotal			2.00
Objective 9			
1. Develop prevention models.	HRY/SESS/Managed Care/Predictor Variables	100.00	34.83
Subtotal			34.83
Objective 10			
1. New prevention research.	COSAP/Teen Parents	100.00	13.00
2. Disseminate information.	Improve Service	100.00	0.00
3. Anti-drug education impact study.			
Subtotal			13.00
Resources not aligned to an existing objective.	HHS/SAMHSA Taps, SAMHSA Crosscuts, Logis.	100.00	7.80
Drug free workplace	Workplace Program	100.00	7.37
Prevention Training	Faculty Development Program	100.00	0.80
Prevention Program Management	Program Management	100.00	12.36
OAS Surveys and Studies	SAPT Block Grant Set-aside *	100.00	27.45
Subtotal			55.78
Total for Goal 1			402.99
Goal 2			
Objective 4			
1. Drug testing policies.			
2. Positive drug test responses.			
3. Abuse treatment availability.	CJ Treatment Networks	100.00	8.20
	CJ Diversion	100.00	3.00
4. Drugs and recidivism.			
Subtotal			11.20
Objective 5			
1. Inmate access to illegal drugs.			
2. Break-the-Cycle ("BTC") demonstration.			
3. Drug-crime focused court reform.	Drug Court Activities	100.00	0.46
Subtotal			0.46
Resources not aligned to an existing objective.			NA
Total for Goal 2			11.66

I. RESOURCE SUMMARY - Detail by Goal and Functions

($ in millions)

I. RESOURCE SUMMARY - Detail by Goal and Functions (con=t)

($ in millions)

	Program Title	Drug-Related Percent	FY 1998 Actual
Goal 3			
Objective 1			
1. Treatment gap.	Targeted Capacity Expansion	100.00	24.73
	SAPT Block Grant	71.07	725.32
2. Demonstration impact.			
3. Waiting time.	Hotline	100.00	0.20
4. Implement NTOMS.			
5. Disseminate treatment information.	Managed Care Activities	100.00	4.80
	SAPT Block Grant Set-Aside Activities *	100.00	7.15
	Dissemination	100.00	3.00
	National Leadership Institute	100.00	8.15
	Treatment Improvement Protocol Series (TIPS) *	100.00	1.80
	National Centers (GAINS, Advanced Technology Support)	100.00	1.30
	Communication Activities	100.00	1.30
	Best Practices	100.00	0.00
Subtotal			777.75
Objective 2			
1. Tuberculosis.			
2. Hepatitis B.			
3. HIV.	Cross-Training/Hotline	100.00	0.59
	HIV/AIDS Activities	100.00	1.15
Subtotal			1.74
Objective 4			
1. Standards set.	Addiction Technology Transfer Ctrs (ATTC)	100.00	7.55
	Training Activities	100.00	1.60
2. Conformity.			
Subtotal			9.15
Objective 5			
1. Research focus.	Exemplary Programs	100.00	2.12
	Methadone Accreditation	100.00	3.90
	Managed Care Studies	100.00	7.90
	Comprehensive Community Trmt (Women and Children, Rural, SSI, Co-occurring, Homeless, Domstic Violence, TANF, SE/SS)	100.00	39.36
	Special Drug Studies (Alcohol, Methamphetamine and Marijauna)	100.00	10.00
	CSAT Data	100.00	2.70
	Pharmacologic Alternatives	100.00	0.00
Subtotal			65.98
Objective 6			
1. Develop funded portfolio.	Treatment Episode Outcomes	100.00	2.00
	Persistent Effects of Treatment Study	100.00	7.20
	Managed Care Evaluation	100.00	0.80
2. Epidemiological model.	Needs Assessment *	100.00	7.00
	Cost Profiles	100.00	0.80
	National Health Spending	100.00	1.60
	TOPPS II *	100.00	9.00
3. Health/social cost model.			
Subtotal			28.40
Resources not aligned to existing objective	Taps, Support, Logistics	100.00	7.80
	Community Recovery Support Program	100.00	3.66
Treatment Program Management	Program Management	100.00	10.90
Subtotal			22.36
Total for Goal 3			905.37
Grand Total			1,320.02

Footnotes

NA Not Applicable

***** Identifies Substance Abuse Prevention and Treatment (SAPT) Block Grant Set-aside Funding.

The grand total of all block grant dollars on this table will not agree with the total SAPT Block Grant, as appropriated. For the Drug Abuse Budget, SAMHSA does not score funding for persons who only abuse alcohol. However, programs that involve abuse of alcohol and other drugs together, or illegal use of alcohol by persons under age 21, are scored for the Drug Abuse Budget.

Estimates of Number of Persons Needing and Receiving Treatment for Drug Abuse Problems: NHSDA 1991-97

	Number of Persons (in 1,000's)						
	1991	1992	1993	1994	1995	1996	1997
Total Drug Abuse Treatment Need	8,991	8,599	8,067	8,329	8,906	9,383	9,474
Level 1 Treatment Need							
Persons with Less Severe Problems Needing Treatment	3,843	3,881	3,326	3,719	4,260	4,080	3,748
Level 2 Treatment Need							
Persons with Severe Problems Needing Treatment	5,148	4,718	4,741	4,610	4,646	5,303	5,726
Persons Receiving Treatment	1,649	1,814	1,848	1,984	2,121	1,973	2,137
Percent of Level 2 Treated	32%	38%	39%	43%	46%	37%	37%
Percent of Level 2 Not Treated	68%	62%	61%	57%	54%	63%	63%
Treatment Gap	3,499	2,904	2,893	2,626	2,525	3,330	3,589

Note: Estimates for 1991-97 are ratio-adjusted to partially account for underestimation due to underreporting and undercoverage in the NHSDA. Estimates for 1991-93 are also adjusted for trend consistency, to account for the change in the NHSDA questionnaire in 1994. Adjustment factors for trend consistency were 1.19020 for total treatment need and 1.21125 for Level 2 treatment need.

Source:
Office of Applied Studies, SAMHSA. Unpublished data from the National Household Survey on Drug Abuse and Uniform Facility Data Set.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

Number of Persons Receiving Treatment with SAMHSA Funding

(Dollars in Thousands)

	1998 Actual	1999 Enacted	2000 Request	Increase in $ / Pers Svd 2000 vs 1999	Percent Increase 2000 vs 1999
SAMHSA Drug Treatment Funds	$793,446	$920,085	$987,617	$67,532	7.34%
Average Cost--Per Person/Per Year	$2,336	$2,397	$2,447	$50	2.09%
Persons Served w/ SAMHSA Funds	339,631	383,858	403,603	19,746	5.14%
KDA Programs	*28,066*	*24,330*	*23,832*	(498)	-2.05%
Targeted Treatment Capacity Programs	*10,586*	*23,043*	*45,048*	22,005	95.50%
SAPT Block Grant Programs	*300,978*	*336,485*	*334,723*	(1,762)	-0.52%

NOTE: The SAPT Block Grant-funded portion of all publicly-funded treatment is approximately 40 percent of the total. By leveraging States and local governments to continue contributing their 60 percent share of publicly-funded treatment, the number of persons treated would be as shown in the table to the right.

	Increase	Total
Fed - SAPT	**(1,762)**	**334,723**
Fed - Other	**21,507**	**68,880**
State/Local	**(2,643)**	**502,084**
Total	**17,103**	**905,688**

HIV/AIDS Budget

(Dollars in thousands)

	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate
Knowledge Development and Application	$9,181	$10,055	$10,647
Mental Health (Non-add)	*(8,028)*	*(8,902)*	*(9,492)*
Substance Abuse Treatment (Non-add)	*(1,153)*	*(1,153)*	*(1,155)*
Targeted Capacity Expansion	1,000	28,000	28,000
Substance Abuse Prevention (Non-add)	*(1,000)*	*(9,500)*	*(9,500)*
Substance Abuse Treatment (Non-add)	---	*(18,500)*	*(18,500)*
Substance Abuse Block Grant (Set-aside)	54,846	54,208	56,304
Program Management	580	580	580
Total, SAMHSA	$65,607	$92,843	$95,531

HIV/AIDS by Functional Category

(Dollars in thousands)

Functional Categories	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate
II. Risk Assessment and Prevention:			
C. Information and Education/Preventive Services:			
1. High risk or infected persons:			
a. Health education/risk reduction	$3,100	$12,760	$12,426
Subtotal, High Risk or Infected Persons	3,100	12,760	12,426
5. Health-care workers and providers	3,951	3,642	3,566
Subtotal, Information and Educ./Preventive Services	7,051	16,402	15,992
Total, Risk Assessment and Prevention	7,051	16,402	15,992
IV. Clinical Health Services Research and Delivery:			
A. Services:			
1. Community and mental health center services	1,977	2,000	3,000
* 2. Mental Health Systems Change	---	---	---
3. Substance abuse treatment improvement program	56,579	74,441	76,539
Subtotal, Services	58,556	76,441	79,539
Total, Clinical Health Services Res. and Delivery	58,556	76,441	79,539
Total, SAMHSA	$65,607	$92,843	$95,531

SAMHSA HIV/AIDS ACTIVITIES

Overview

Reports on HIV infection in the United States suggest that more than 50 percent of new HIV cases are directly or indirectly related to injecting drug use. This underscores the urgency in addressing the dual epidemics of substance abuse and HIV/AIDS. Current estimates suggest that there are more than 21 million substance abusers in this country. The National Institute on Drug Abuse estimates that there are approximately 1.5 million injecting drug users, many of whom are multiple drug users. In addition, the sexual partner(s) and unborn children of injecting drug users are at great risk of exposure to HIV infection. Of newly diagnosed AIDS cases in 1997, 25% were directly attributable to injection drug use (IDU). However, among minority men the percentage of IDU related AIDS cases exceeded 31%. An additional 4% of new cases were attributable to injection drug use among men who have sex with men (MSM).

The status of the HIV/AIDS epidemic is a continuous severe and ongoing crisis that has been unchecked in communities of color, and especially in the African American and Hispanic communities. The burden of HIV/AIDS on racial and ethnic minorities is a severe and ongoing crisis that requires both immediate measures and a long term sustained commitment to overcome. According to the Centers for Disease Control and Prevention (CDC), AIDS is now the leading cause of death among African American, ages 25 to 44. Racial and ethnic minorities together account for more than 54% of the total AIDS cases reported since the beginning of the epidemic. Latinos account for 18% of the total AIDS cases.

The effect of HIV among substance abusing populations is quite evident -- injection drug use accounts for approximately 66 percent of the reported AIDS cases among women; 61 percent of the reported pediatric AIDS cases; and 30 percent of the total male AIDS cases. This does not take into account AIDS cases related to alcohol and other non-injection drug use (including crack cocaine use). Being under the influence of alcohol and/or drugs, and/or having a mental illness, greatly increases an individual=s likelihood of engaging in unsafe sex practices, including having multiple sex partners that can lead to transmitting HIV.

The impact of HIV on the mental health status of persons living with HIV/AIDS is also of critical concern to SAMHSA. To date, more than 650,000 AIDS cases have been reported in the United States, and current CDC estimates suggest that there are 600,000 to 900,000 people infected with the virus. An additional 40,000 new HIV infection are estimated every year. The current public mental health system in this country does not have the capacity to meet all the mental health needs of those infected with the HIV much less those affected by HIV and AIDS. It is important that services addressing the needs of this population are maintained and/or enhanced.

Since its inception, SAMHSA has supported HIV/AIDS related activities through its Centers. SAMHSA=s Center for Mental Health Services (CMHS) has supported a portfolio of projects since October 1992, designed to educate and train traditional and non-traditional mental health care providers to address the mental health needs of HIV infected persons and those at risk for HIV infection. Since October 1992,

more than 64,000 mental health care providers have received specialized training supported by the CMHS program.

SAMHSA=s Center for Substance Abuse Treatment (CSAT) has supported HIV/AIDS related activities through demonstration programs and the Substance Abuse Prevention and Treatment (SAPT) Block Grant. States whose AIDS case rate is 10 or more per 100,000 population, are required to expend 2-5 percent of the block grant to establish one or more projects to make available HIV/AIDS early intervention services at substance abuse treatment sites. In FY 1999, the HIV set-aside will amount to approximately $54.2 million. In addition, SAMHSA=s Center for Substance Abuse Prevention (CSAP) has supported HIV prevention activities targeting high risk adolescents through its High Risk Youth Program.

SAMHSA has been increasingly involved to address the interconnected epidemics of substance abuse and HIV/AIDS. In August 1996, SAMHSA along with other Federal agencies and national organizations co-sponsored a forum to bring substance abuse and HIV/AIDS policy makers, and service providers together to improve collaboration and integration of substance abuse and HIV prevention. In addition, SAMHSA=s Office on AIDS convened a group of experts from the field to assist in the development of effective plans to ensure that substance abuse prevention and treatment, and mental health are fully integrated with HIV/AIDS prevention strategies and to recommend Knowledge Development and Application (KDA) study questions in the area of HIV/AIDS as it relates to substance abuse prevention and treatment, and mental health. In 1997, SAMHSA co-sponsored national organizations HIV/AIDS conferences, i.e., the Latino Lesbian and Gay Organization (LLEGO), the United States Conference on AIDS, and Men who Have sex with Men Conference. SAMHSA=s participation in these most significant conferences will not only improve collaboration efforts, but also encourage information sharing and data gathering and linkages for SAMHSA=s activities and development of a strategic plan for HIV/AIDS.

In 1998, SAMHSA developed an interagency agreement to fund the National Association of State and Territorial AIDS Directors (NASTAD) to collect and develop informational data on how the states are collaborating around issues relating to HIV/AIDS and substance abuse. Because the majority of the AIDS cases among African American women and children are directly or indirectly attributable to alcohol and other drug use, SAMHSA has also entered an interagency agreement to fund the National Minority AIDS Council (NMAC) to develop engaging forums to provide a unique opportunity to gather relevant data to assist SAMHSA policy and program staff in developing future strategies to address HIV/AIDS and women related issues. The SAMHSA AIDS Office has initiated the development of a strategic plan for SAMHSA=s HIV/AIDS activities and programs. SAMHSA and the Office of National AIDS Policy entered a staff sharing agreement. This arrangement with the Director, Sandy Thurman, worked very well and enhanced linkages between the two offices in addressing further collaboration on substance abuse and mental health issues and HIV/AIDS. As in 1997, in 1998, SAMHSA participated in the US Conference on AIDS in Dallas, Texas, and conducted a three-hour seminar with participation from CSAT grantees.

SAMHSA has played a major role in the development of the HHS response to the Congressional Black Caucus (CBC). SAMHSA staff has participated in all facets of the CBC initiatives and SAMHSA response. These processes have built stronger linkages and collaboration among SAMHSA and the Department to include HRSA, CDC, NIH, and the Office of Minority Health.

In FY 1999, SAMHSA was provided $22 million for the Congressional Black Caucus Initiative for comprehensive substance treatment and prevention programs for certain minority populations at risk for HIV or living with HIV/AIDS. These include: substance abusing African American and Hispanic men (including men who have sex with men), women and young people. The Center for Substance Abuse Treatment and the Center for Substance Abuse Prevention were designed to administer the CBC funded initiatives. These initiatives will be discussed under the listing of CSAT=s and CSAP=s HIV/AIDS activities and will continue in FY 2000.

In FY 2000, SAMHSA and its Centers will continue to pursue and participate in collaborative efforts with other Federal agencies such as the CDC, NIH, HRSA, IHS and HCFA as well as our State partners and national constituency organizations to address the multifaceted needs of substance abusers at high risk for HIV infection or living with HIV disease. SAMHSA will utilize information and data gathered from the CBC initiatives and activities to continue to target activities and linkages to eradicate and minimize substance use and HIV infection in those communities at high risk.

SAMHSA is committed to developing and implementing a response that both maximizes the effectiveness of existing programs to serve racial and ethnic minority communities confronting HIV/AIDS and substance abuse and mental illness disorders and developing new and innovative strategies that target assistance to address specific needs. With more cases attributable to injecting drug use among African Americans, efforts to stop HIV transmission must include substance abuse prevention and treatment programs and mental health support services as part of the array of strategies being offered.

Center for Mental Health Services

Accomplishments

Mental Health Services Demonstration Program

This program was a collaborative effort of SAMHSA, CMHS, HRSA, and NIH. It was the first Federal effort to develop models of delivery of mental health services to people living with and/or affected by HIV/AIDS. This program has shed new light on how to develop services and develop systems of care. Findings from the program indicated that early intervention with mental health services can improve adherence to medical and other treatments. Mental health treatment services and HIV education play an important role in preventing children and adolescents whose parents have HIV or AIDS from acquiring the virus themselves. These and other important findings are currently being disseminated to the field.

Current Activities

HIV/AIDS High Risk Prevention/Intervention

Project SHIELD: The *HIV/AIDS High-Risk Behavior Prevention/Intervention Model for Young Adults/Adolescents and Women Program* is a collaborative venture aimed at bringing AIDS prevention into the community. Project SHIELD also represents an opportunity to move the field of HIV prevention research forward along the two parallel continuums of innovative intervention design and rigorous evaluation.

The multisite nature of this HIV prevention trial has the potential to test the efficacy of two brief interventions and generalize the study results to more than one study population. In essence, the question posed by Project SHIELD is: can the principles underlying demonstrably effective HIV prevention interventions be applied in brief formats to real world client and still be effective in reducing HIV risk behaviors? Although the HIV prevention field has traditionally relied on self reports of risk behaviors as the primary outcome Project SHIELD will not only measure participants= self reported behavior change, which may be biased, but will *actually* measure reductions in diseases; diseases such as common STDs that are associated with considerable adverse sequelae and may facilitate HIV transmission.

HIV/AIDS Mental Health Provider Education Program

The *HIV/AIDS* Mental Health Care Provider Education Program completed its final year of funding in FY 1998. Grants have been awarded in the Mental Health Provider Education in *HIV/AIDS* Program II to evaluate the dissemination of knowledge on (1) the psychological and neuropsychiatric sequelae of HIV/AIDS, and (2) the ethical issues in providing services to people with HIV/AIDS, to both traditional and nontraditional first-line providers of mental health services, and to evaluate the relative effectiveness of different education approaches. Training approaches are incorporating the most current research-based information and allow easy modifications to reflect changes in the medical regimen for treatment of AIDS.

The HIV/AIDS Treatment Adherence/Health Outcome and Costs Study

The HIV/AIDS Treatment Adherence/Health Outcome and Costs Study reflects the collaboration of six Federal entitiesCthe Center for Mental Health Services, which has lead administrative responsibility, and the Center for Substance Abuse Treatment, both of which are components of the Substance Abuse and Mental Health Services Administration (SAMHSA); the HIV/AIDS Bureau in the Health Resources and Services Administration (HRSA); and the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, all components of the National Institutes of Health (NIH). The HIV/AIDS Cost Study is the first-ever Federal initiative designed to study integrated mental health, substance use, and primary medical HIV treatment interventions. More importantly, the study is the first Federal effort to determine if an integrated approach to care improves treatment adherence, produces better health outcomes, and reduces the overall costs associated with HIV treatment.

FY 2000 Agenda

A new *Continuum of Care program* will examine the extent to which mental health services improve the utilization of all health and human services, improve health and social outcomes, and improve the outcomes of the next generation of children by preventing behaviors that increase risk of contracting HIV/AIDS. The program will seek to increase compliance with medical regimens as well as mental health and substance abuse treatment, reduce risky behaviors, improve life outcomes for children affected by HIV/AIDS, and inform the field of effective models of service and models for integration of services and evaluation that can be replicated.

Center for Substance Abuse Prevention

Substance Abuse and HIV/AIDS Prevention for Youth and Women of Color: This $6 million effort, initiated in FY 1999, responds to the pressing Astate of emergency@ that exists with respect to the extent and impact of HIV/AIDS on the Black community as highlighted by members of the Congressional Black Caucus (CBC). The overwhelming majority of AIDS cases among African American women and children is directly or indirectly attributable to alcohol or illicit drug use. The CBC has characterized the burden of HIV/AIDS on racial and ethnic minorities as a severe and ongoing crisis which requires both immediate measures and a long term commitment to resolve. The Substance Abuse and HIV/AIDS Prevention for Youth and Women of Color Initiative focuses on providing HIV/substance abuse prevention services to African American and Hispanic youth and women, with a particular focus on designated hard-hit communities and building capacity for improved training and technical assistance.

A major component of this initiative is a Substance Abuse/HIV Prevention Targeted Capacity Expansion program which provides funds to community-based organizations, Historical Black Colleges and Universities, Hispanic Colleges and Universities, Faith communities, and other coalitions and/or partnerships for the purpose of strengthening the integration of HIV and substance abuse prevention services at the local level and increasing the provision of integrated services to African American and Hispanic youth and women. The HIV/AIDS initiatives will also work with CSAP=s Centers for the Application of Prevention Technology (CAPTs) to enable them to integrate HIV prevention into their substance abuse prevention materials and curricula and to help build capacity within the CAPTs to provide training and technical assistance to community based organizations and other providers in the hardest hit communities. Finally, the HIV/AIDS initiative will partner with national organizations to undertake several key roles, including accessing and retaining minority youth and women in prevention programs, ensuring the applicability and feasibility of proposed community programs, coordinating and convening the component service and training programs of the initiative, and providing technical assistance to the CAPTs in the incorporation of HIV prevention within substance abuse prevention materials and curricula available from them.

Center for Substance Abuse Treatment

In FY 1999, CSAT was appropriated $16 million to address the issue of the crisis that exists with respect to the extent and impact of *HIV/AIDS in the Black Community* as highlighted by members of the Congressional Black Caucus (CBC). In response to this issue and the increasing number AIDS case rate among minorities, CSAT plans to award grants to augment, expand and enhance substance abuse treatment services that include an HIV component. These grants will be restricted to metropolitan areas with AIDS case rates of 25 per 100,000 or higher and States with AIDS case rates of 10 or more per 100,000 (as reported in the CDC=s HIV/AIDS Surveillance Report). These funds will be earmarked for comprehensive substance abuse treatment programs for substance abusing African American and Hispanic populations at risk of contracting HIV, including women and their children and men who have sex with men (MSM).

Substance Abuse Block Grant HIV/AIDS Activities

Current SABG guidance for allocation of block grant funds to the States requires that 2% - 5% of the allocation must be spent on HIV/AIDS-related substance abuse programs in States with an AIDS case rate of 10 per 100,000 population (reported at $53 million from the total block grant funding in the latest year for which data were available).

Full-Time Equivalent Employment (FTE) Ceiling

	FY 1998 Actual	FY 1999 Current Estimate	FY 2000 Estimate
Office of the Administrator	80	83	83
Office of Applied Studies	29	31	31
Office of Program Services	103	106	106
Center for Mental Health Services	124	125	125
Center for Substance Abuse Prevention	122	128	128
Center for Substance Abuse Treatment	112	120	120
Total, SAMHSA	570	593	593

Average GS Grade

1996.....11.04
1997.....11.04
1998.....11.70
1999.....11.67
2000.....11.67

Detail of Positions

	FY 1998 Actual	FY 1999 Appropriation	FY 2000 Estimate
Executive Level I	---	---	---
Executive Level II	---	---	---
Executive Level III	---	---	---
Executive Level IV	1	1	1
Executive Level V	---	---	---
Subtotal	1	1	1
ES-6	3	3	3
ES-5	1	2	3
ES-4	5	4	3
ES-3	0	1	1
ES-2	1	0	2
ES-1	2	3	1
Subtotal	12	13	13
GM/GS-15	62	65	64
GM/GS-14	112	117	118
GM/GS-13	151	158	158
GS-12	37	37	38
GS-11	19	19	18
GS-10	3	3	3
GS-9	24	24	24
GS-8	23	24	24
GS-7	53	57	58
GS-6	23	24	23
GS-5	11	11	11
GS-4	4	4	4
GS-3	0	0	0
GS-2	1	1	1
GS-1	1	2	2
Subtotal	524	546	546
CC-08/09	0	0	0
CC-07	0	0	0
CC-06	18	18	18
CC-05	7	7	7
CC-04	5	5	5
CC-03	2	2	2
CC-02	1	1	1
CC-01	0	0	0
Subtotal	33	33	33
TOTAL Full-Time Equivalent Ceiling	570	593	593
Full-Time Equivalent Usage	549	574	565
Average GS Grade	11.70	11.67	11.67

SAMHSA

GPRA PERFORMANCE PLAN
FOR FY 2000
AND
REVISED FINAL PERFORMANCE PLAN
FOR FY 1999

JANUARY 1999

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Table of Contents - SAMHSA Performance Plan

SAMHSA Measures Summary - FY 2000 GPRA Performance Plan

This table summarizes and compares, side-by-side, the performance measures from SAMHSA=s FY 2000 and FY 1999 GPRA plans. The table also contains information on when baseline data was or will be available; when targets will be determined if baseline data are not now available; and when progress data will be available if it is not now available. In all cases, SAMHSA intends to provide update data on an annual basis.

The first several pages of the table show long-range policy measures, program goal measures, and client outcome measures that were developed in FY 1999 for application across all SAMHSA programs to which they are appropriate. These measures will begin to be applied in FY 1999, generating baseline data in most cases in FY 2000 and update data on an annual basis beginning in FY 2001. Accordingly, all of these common measures are developmental in nature.

The remaining sections of the table show measures for individual SAMHSA programs. These sections also contain some measures developed in the past year which did not appear in the FY 1999 GPRA plan. The table shows these changes.

SAMHSA Measures - Long Term Policy Goals

Support and contribute to the improvement of community-based systems of mental health care to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious emotional disturbances.		
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Increase the percentage of adults with serious mental illness who are currently employed or engaged in productive activities; have a permanent place to live in the community; have not had contact with the criminal justice system. Increase the percentage of children with serious emotional disturbances who attend school regularly; reside in a stable environment; and have no contact with the juvenile justice system. Specific targets have not yet been established pending availability of baseline data. *Target:* TBD	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001 Note: SAMHSA core client outcome measures will be utilized to generate these data.

Educate and enable Americæs youth to reject illegal drugs as well as underage use of alcohol.		
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Reverse upward trend and cut monthly marijuana use among 12 to 17-year-olds by 25 percent from the 1995 baseline of 8.2 percent to 6.2 percent by the end of FY 2002. By 2002, reduce the prevalence of past month use of illegal drugs and alcohol by youth by 20 percent as measured against the 1996 base year. By 2007, reduce this prevalence by 50 percent. Reduce tobacco use by youth by 25 percent by 2002 and by 55 percent by 2007. *Target:* see measures above.	New in FY 2000	Baseline: FY 2000 Targets determined. Update: FY 2001 Note: National baseline data already are available, updated each year. Program-level data will begin to be generated in FY 2000.

Assist States and communities by supporting and helping to improve their substance abuse prevention and treatment efforts.		
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
(a) Increase the percentage of adults receiving substance abuse services who are currently employed or engaged in productive activities; had a permanent place to live in the community; had no or reduced involvement with the criminal justice system; experienced no or reduced alcohol or illegal drug related health, behavior, or social consequences, and had no past month substance abuse (Specific targets have not yet been established pending availability of baseline data). By 2007, as compared to the 2001 base year, achieve for those completing substance abuse treatment programs a: 10 percent increase in full time employment (adults); a 10 percent increase in educational status (adolescents); a 10 percent decrease in illegal activity; and a 10 percent increase in general medical health. (b) Reduce the size of the treatment gap, defined as the difference between those seeking treatment and those receiving it. By 2002, reduce the public treatment gap by at least 20 percent as compared to the 1996 base year; by 2007, reduce the gap by at least 50 percent. National data source under consideration in cooperation with ONDCP. SAMHSA will collect program level data. *Target for (a):* TBD. *Target for (B)*: Consistent with ONDCP PME	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001 Note: SAMHSA core client outcome measures and other program data will be utilized to generate data. A national data source for these measures does not exist at this time.

SAMHSA Measures - Program Goals

Goal 1: Bridge the Gap between knowledge and practice.		
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Increase the percentage of completed knowledge development activities that are recommended for further dissemination as a knowledge application program *Target*: TBD	New in FY 2000	Baseline: FY 2000 Targets TBD:FY 2000 Update:FY 2001

Goal 2: Promote the adoption of best practices.		
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Increase the percentage of completed knowledge application activities that change user practice, or are adopted by users *Target*: TBD	New in FY 2000	Baseline:FY 2000 Targets TBD: FY 2000 Update: FY 2001

Goal 3: Assure services availability / meet targeted needs		
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Increase the percentage of completed targeted capacity expansion activities that assured service availability or otherwise met the identified need. *Target*: TBD	New in FY 2000	Baseline: FY 2000 Target TBD: FY 2000 Update:FY 2001

Goal 4: Enhance service system performance		
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Increase the utility of Federal, State, and local data to enhance service system performance. *Target*: TBD	New in FY 2000	Baseline: FY 2000 Target TBD:FY 2000 Update:FY 2001

SAMHSA and Program Level Measures - CORE CLIENT OUTCOMES

Goal: Increase client outcomes in SAMHSA funded programs		Note: To be applied to all SAMHSA discretionary programs, as appropriate.
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Substance Abuse Prevention Measures (Children): Over the past month, the percent of children: a) Using substances declined for those receiving services compared to the national average or project baselines b) Strongly disapproving of substance use increased for those receiving services compared to the national average or project baselines c) Perceiving personal/health risks associated with the consequences of substance abuse increased for those receiving services compared to the national average or project baselines *Target:* TBD	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
Substance Abuse Prevention Measures (Adults): Over the past month, the percent of parents/adults: a) Using illegal drugs declined for those receiving services compared to the national average or project baselines. b) Strongly disapproving of substance use increased for those receiving services compared to the national average or project baselines. c) Perceiving personal/health risks associated with the consequences of substance abuse/misuse increased for those receiving services compared to the national average or project baselines. *Target:* TBD	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
Mental Health and Substance Abuse Treatment Measures (Children): Over the past year, percent of children/adolescents under age 18 receiving services who: a) were attending school b) were residing in a stable living environment c) had no involvement in the juvenile justice system d) had no past month use of alcohol or illegal drugs (population data limited to 12-17 year olds) *Target:* TBD	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001

Goal: Increase client outcomes in SAMHSA funded programs		Note: To be applied to all SAMHSA discretionary programs, as appropriate.
<u>Mental Health and Substance Abuse Treatment Measures (Adults)</u>: Over the past year, percent of adults receiving services increased who: a) were currently employed or engaged in productive activities b) had a permanent place to live in the community c) had reduced involvement with the criminal justice system d) experienced reduced alcohol or illegal drug related health, behavior, or social consequences, including the misuse of prescription drugs *Target:* TBD	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
<u>Additional Measures for Substance Abuse Treatment and Prevention</u>: Over the past month, the percent increase of adults receiving services who had no past month use of illegal drugs or misuse of prescription drugs *Target:* TBD Over the past month, the percent increase of youth (population data limited to 12-17 year olds) receiving services who experienced no substance abuse related health, behavior, or social consequences *Target:* TBD	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update:FY 2001

SAMHSA Program Goal 3: Assure Services Availability / Meet Targeted Needs

Program Level Measures - Block Grants

CMHS Community Mental Health Services Block Grant **Goal: To improve community based systems of care in order to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious emotional disturbances.**		FY 1997 Actual: $275,420,000 FY 1998 Actual: $275,420,000 FY 1999 Enacted: $288,816,000 FY 2000 Estimate: $358,816,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Increase % of adults with serious mental illness who are employed, are living independently, and have had no contact with the criminal justice system. Increase % of children with serious emotional disturbance who attend school regularly, reside in a stable environment, and have no contact with the juvenile justice system. *Target:* TBD	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
Measure 2. Ten States will pilot 28 performance indicators *Target:* TBD	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
	Measure 1.Increase satisfaction with technical assistance to 80%	Dropped
	Measure 2. Increase to 80% the proportion of States that utilize common definitions and data collection approaches	Dropped

CSAP Substance Abuse Prevention Set-aside From SAPT Block Grant **Goal: To expand and enhance substance abuse prevention services**		FY 1997 Actual: $248,920,000 FY 1998 Actual: $248,920,000 FY 1999 Enacted: $301,150,000 FY 2000 Estimate: $306,850,000

CSAP Substance Abuse Prevention Set-aside From SAPT Block Grant **Goal: To expand and enhance substance abuse prevention services**		FY 1997 Actual: $248,920,000 FY 1998 Actual: $248,920,000 FY 1999 Enacted: $301,150,000 FY 2000 Estimate: $306,850,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Increase % of States that incorporate needs assessment data into block grant application *Target*: TBD	Was Measure 3. Similar to FY 2000. Tentative target was 45%	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
Measure 2. Increase % of States that use funds in each of 6 prevention strategy areas *Target*: TBD	Was Measure 1. Same as FY 2000. Tentative target was 80%	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
Measure 3. Maintain satisfaction with TA *Target*: 90%	Was Measure 5. Same measure and target as FY 2000.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 4. Identify and complete testing of prevention performance outcome measures *Target*: 5 outcome measures tested in 11 States	Was Measure 6. Same measure and target as FY 2000.	Baseline: FY 1998 Targets Determined. Update: Annually
	Measure 2. 30% of States use 20% of grant to fund community mobilization and empowerment strategies	Dropped
	Measure 4. 30% of States use validated and standardized measure for States' prevention program	Dropped

CSAT Substance Abuse Prevention and Treatment Block Grant **Goal: To support prevention and treatment service**		FY 1998 Actual: $1,310,107,000 FY 1999 Enacted: $1,585,000,000 FY 2000 Estimate: $1,615,000,000 (These are totals before deducting 20% Prevention Set-Aside)

CSAT Substance Abuse Prevention and Treatment Block Grant **Goal: To support prevention and treatment service**		FY 1998 Actual: $1,310,107,000 FY 1999 Enacted: $1,585,000,000 FY 2000 Estimate: $1,615,000,000 (These are totals before deducting 20% Prevention Set-Aside)
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Outcome indicators will be reported voluntarily as part of FY 2000 block grant application Over the past year, percent of adults receiving services increased who: a. were currently employed or engaged in productive activities b. had a permanent place to live in the community c. had no/reduced involvement with the criminal justice system d. experience no/reduced alcohol or illegal drug related health, behavior, or social consequences, e. had no past month substance abuse Over the past year, percent of children/ adolescents under age 18 receiving services increased who: a. were attending school b. were residing in a stable living environment c. had no/reduced involvement in the juvenile justice system d. had no past month use of alcohol or illegal drugs (population data limited to 12-17 year olds), e. experienced no/reduced substance abuse related health, behavior, or social consequences *Target:* TBD	New in FY 2000	Baseline: FY 2001 Targets TBD: FY 2001 Update: FY 2002
Measure 2. Develop and implement performance outcome measures for SAPT block grant *Target:* TBD	New in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
Measure 3. Increase % of States that express satisfaction with TA provided *Target:* TBD	Was Measure 4. Same as FY 2000. Tentative target: 85%	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
Measure 4. Increase % of TA events that result in systems, program or practice change *Target:* TBD	Was Measure 5. Same as FY 2000. Tentative target: 50%	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
	Measure 1: Increase to 75%	Dropped

CSAT Substance Abuse Prevention and Treatment Block Grant **Goal: To support prevention and treatment service**		FY 1998 Actual: $1,310,107,000 FY 1999 Enacted: $1,585,000,000 FY 2000 Estimate: $1,615,000,000 (These are totals before deducting 20% Prevention Set-Aside)
	the proportion of BG applications received electronically	
	Measure 2: Increase to 80% the proportion of BG applications which include needs assessment data from CSAT's needs assessment program	Dropped
	Measure 3: Identify and pilot 7 treatment outcome measures in 7 States	Dropped

CMHS Children's Mental Health **Goal: To improve outcomes for children and their families by implementing systems of care for children serious emotional disturbance.**		FY 1997 Actual: $69,896,000 FY 1998 Actual: $72,927,000 FY 1999 Enacted: $78,000,000 FY 2000 Estimate: $78,000,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Increase Interagency collaboration: -Referrals from non-MH agencies for MH services will increase *Target*: 10% -Referrals from juvenile justice programs will increase *Target*: 12% -Case records that reflect cross-agency treatment planning will increase *Target*: 10%	Same as FY 2000. Target for each element was 5%.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 2. Decrease utilization of Inpatient/residential treatment (avg days in facility) *Target*: 20% of FY 1997 baseline	Same as FY 2000. Target was 20%.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 3. Children's outcomes: -Increase the number of children attending school 75% of the time *Target*: 10% -Increase the number of children with law enforcements contacts at entry who have no law enforcement contacts after 6 months *Target*: 57%	Was Measures 3 & 4. Target was 10% for school attendance. Measure for law enforcement was to increase referrals from Juvenile Justice by 10%.	Baseline: FY 1997 Targets Determined. Update: Annually Note: Revised FY 2000 measure for law enforcement better captures the outcome.
Measure 4. Increase level of family satisfaction with services *Target:* 10% over FY 1997 baseline	Was Measure 5. Same as FY 2000. Target unchanged.	Baseline:FY 1997 Targets Determined.: Update: Annually
Measure 5. Increase stability of living arrangements by decreasing the number of children having more than one living arrangement within 6 months *Target:* 25% over FY 1997 baseline	Was Measure 6. Target was 10%.	Baseline: FY 1997 Targets Determined. Update: Annually

CMHS Protection and Advocacy **Goal: Through advocacy activities, to reduce incident of abuse, neglect, and civil rights violations of individuals with mental illness in residential facilities.**		FY 1997 Actual: $21,957,000 FY 1998 Actual: $21,957,000 FY 1999 Enacted: $22,957,000 FY 2000 Estimate: $22,957,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. At least 9,000 complaints of abuse will be addressed by State PAIMI systems *Target*: 9,000	New in FY 2000.	Baseline: FY 1997 Target determined. Update: Annually
Measure 2. Maintain the number of individuals attending public education and training activities and public awareness activities *Target*: 160,000	Same as FY 2000. FY 1999 target revised based on baseline data. Original FY 1999 target: 120,000; revised FY 1999 target 160,000.	Baseline: FY 1996 Targets determined. Update: Annually
Measure 3. Maintain the percentage of priorities and goals that have made substantial progress *Target*: 70%	Same as FY 2000. Same target.	Baseline: FY 1997 Targets determined. Update: Annually
Measure 4. Increase the number of substantiated incidents of abuse, neglect or rights violations reported by clients which are favorably resolved *Target*: TBD	Same as FY 2000. Tentative target was 55%.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001

CMHS PATH Homeless Formula Grants **Goal: To provide services to enable persons who are homeless and have serious mental illness to be place in appropriate housing situation and to engage them with formal mental health treatment and systems**		FY 1997 Actual: $20,000,000 FY 1998 Actual: $23,000,000 FY 1999 Enacted: $26,000,000 FY 2000 Estimate: $31,000,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Increase to 115,000 the number of persons contacted relative to population in need *Target*: 115,000/600,000	Same as FY 2000. FY 1999 target has been revised upward from 92,000 to 102,000 based upon latest data.	Baseline: FY 1996 Targets Determined. Update: Annually
Measure 2. Increase the percentage of participating agencies that offer outreach services *Target*: 80%	Same as FY 2000, with a target of 70%	Baseline: FY 1996 Targets Determined. Update: Annually
Measure 3. Maintain the percentage of persons contacted who become enrolled clients at 30% or greater *Target*: 33%	Same as FY 2000, with a target of 30%	Baseline: FY 1996 Targets Determined. Update: Annually

CSAP State Incentive Grants (SIG) **Goal: Assist Governors to coordinate, leverage and/or redirect all substance abuse prevention resources; develop strategy to reduce drug use by youth**		FY 1997 Actual: $15,000,000 FY 1998 Enacted: $55,993,000 FY 1999 Enacted: $61,652,000 FY 2000 Estimate: $61,652,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Increase State collaboration rating *Target:* TBD	New in FY 2000	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
Measure 2. Decrease past month substance use for youth 12-17 *Target:* 15% reduction	New in FY 2000	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000

CSAP Community Coalition Program **Goal: To increase community involvement in dealing with problems of substance abuse and its attendant effects; to promote the development of infrastructure in communities for initiating and facilitating substance abuse prevention activities**		FY 1997 Actual: $36,171,000 FY 1998 Actual: $ 8,318,000 FY 1999 Enacted: $ 6,422,000 FY 2000 Estimate: $ 473,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Project completed. Two measures repeated in FY 2000 performance plan. Final reporting should occur in the FY 2001 plan, after which this program will drop from the plan/report.	Measure 1. Increase the mean number of organizations participating in coalition activities *Target*: 40%	Baseline: FY 1995 Targets Determined. Final data available: FY 1999
	Measure 2. Increase prevention services that promote coalition efforts *Target*: 100%	Baseline: FY 1998 Targets Determined. Final data available: FY 1999
	Measure 3. Number of volunteer hours	Dropped

CSAP Synar Amendment (Section 1926) Implementation **Goal: To reduce the sales rate of tobacco products to minors in all States**		FY 1997 Actual: $1,350,000 FY 1998 Actual: $1,400,000 FY 1999 Enacted: $1,300,000 FY 2000 Estimate: $1,500,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Increase number of States whose rates of tobacco sales to minors viokations is at or below 20% *Target*: 12 States	Was measure 3. Same as FY 2000. Target was 8 States.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 2. Maintain periodic technical assistance for implementation of guidelines *Target:* 100%	Same as FY 2000. Target was to increase to 100%	Baseline: FY 1997 Targets Determined. Update: Annually
	Measure 1.	Dropped

CSAP Synar Amendment (Section 1926) Implementation **Goal: To reduce the sales rate of tobacco products to minors in all States**		FY 1997 Actual: $1,350,000 FY 1998 Actual: $1,400,000 FY 1999 Enacted: $1,300,000 FY 2000 Estimate: $1,500,000
	Develop measure of violation rate	

CSAT Targeted Capacity Expansion **Goal: To address gaps in treatment capacity**		FY 1998 Actual: $24,732,000 FY 1999 Enacted: $55,232,000 FY 2000 Estimate: $110,232,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Increase the proportion of clients served *Target:* TBD	Program first reported in FY 2000.	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001
Measure 2. SAMHSA core measures (Adults and Adolescents: employed or in school; permanent living; reduced involvement with the criminal justice system; no substance abuse related health, behavior or social consequences) *Target:* TBD	Program first reported in FY 2000	Baseline: FY 2000 Targets TBD: FY 2000 Update: FY 2001

SAMHSA Goals 1 and 2

Program Level Measures - Knowledge Development and Application

Note: This program consists of many relatively small Knowledge Development and Application activities. Therefore, only selected examples are shown in the GPRA Performance Plan.

CMHS ACCESS (Knowledge Development) **Goal: To examine the impact of integrated service systems on providing services to persons who are homeless and seriously mentally ill.**		FY 1997 Actual: $19,568,000 FY 1998 Actual: $1,891,000 FY 1999 Enacted: $1,600,000 FY 2000 Estimate: $ 450,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Level of systems integration *Target*: .74	Was Measure 2 (slight rewording). Same target.	Baseline: FY 1994 Targets Determined. Update:Biennially
Measure 2. Client outcomes for days housed, days	Was Measure 3.	Baseline: FY 1996

CMHS ACCESS (Knowledge Development) **Goal: To examine the impact of integrated service systems on providing services to persons who are homeless and seriously mentally ill.**		FY 1997 Actual: $19,568,000 FY 1998 Actual: $1,891,000 FY 1999 Enacted: $1,600,000 FY 2000 Estimate: $ 450,000
of drug use, number of days in outpatient psychiatric services, and percentage committing a minor crime. *Targets: Cohort 4 shows equal or greater improvement than the previous cohorts.*	Same as FY 2000 (slight rewording) *Target*: > cohort 3	Targets Determined. Update: 4th cohort available in late 1999
	Measure 1. 100% implementation of integration strategies	Dropped (completed)

CMHS Employment Intervention Demonstration Program(EIDP) **Goal: Development of the most effective approaches for enhancing competitive employment for adults with severe mental illness**		FY 1997 Actual: $4,840,000 FY 1998 Actual: $4,749,000 FY 1999 Enacted: $3,942,000 FY 2000 Estimate: 0
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Employment outcomes *Target:* TBD	Was Measure 2. Same as FY 2000.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001
Measure 2. Development of direct costs for various models *Target:* TBD	New in FY 2000.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001
	Measure 1. Fidelity assessment	Dropped

CMHS Knowledge Exchange Network (KEN) (Knowledge Application) **Goals: To provide information about mental health to consumers, their families, the general public, policy makers, providers, and researcher**		FY 1997 Actual: $ 453,421 FY 1998 Actual: $1,158,611 FY 1999 Enacted: $1,190,814 FY 2000 Estimate: $1,500,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Increase usefulness of KEN information	Same as FY 2000.	Baseline: FY 1999

CMHS Knowledge Exchange Network (KEN) (Knowledge Application) **Goals: To provide information about mental health to consumers, their families, the general public, policy makers, providers, and researcher**		FY 1997 Actual: $ 453,421 FY 1998 Actual: $1,158,611 FY 1999 Enacted: $1,190,814 FY 2000 Estimate: $1,500,000
Target: TBD		Targets TBD: FY 1999 Update: FY 2000
Measure 2. Increase number of requests for brochures information kits & publications; connects to web telephone inquiries *Target:* 10% increase each year	Same as FY 2000. (Target was a 10% increase over previous year)	Baseline: FY 1998 Targets Determined. Update: Annually

CMHS Community Action Grants for Service Systems Change (Knowledge Application) **Goal: To identify exemplary practices for mental health services to persons with serious mental illness and to accomplish adoption of such practices in as many communities as possible**		FY 1997 Actual: $2,474,000 FY 1998 Actual: $ 3,129,000 FY 1999 Enacted: $ 3,000,000 FY 2000 Estimate: $ 4,500,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1: Phase I grantees achieve consensus and move toward adoption of an exemplary practice. Grantees have appropriate process data *Target*: 50%	Was Measure 2. Same as FY 2000. Same target.	Baseline: FY 1998 Target Determined. Update: Annually.
Measure 2: Exemplary practices funded in Phase I grants are adopted in Phase II grants *Target*: 50%	Was Measure 3. Same as FY 2000. Same target.	Baseline: FY 1999 Target Determined. Update: Annually
	Measure 1. 50 applicants identify & justify an exemplary practice or program that meets CMHS criteria	Dropped

CSAP Predictor Variables (Knowledge Development) **Goals: Generate new knowledge about effective approaches.**		FY 1997 Actual: $5,700,000 FY 1998 Actual: $5,708,000 FY 1999 Enacted: $2,561,000 FY 2000 Estimate: $ 0
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Implement effective models *Target:* 80% of sites Note: This program has been completed and will be reported fully in the FY 2001 plan.	Was Measure 2. Same as FY 2000.	Baseline: FY 1998 Target Determined. Final Data Available: FY 2000
Measure 2. For children 9+, decrease in use of alcohol, tobacco, & drug use compared to children in comparison group *Target:* TBD (Analysis of data collected in 1997 and 1998 is not yet complete).	Was Measure 3. Same as FY 2000.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2000
	Measure 1: All	Dropped

CSAP Predictor Variables (Knowledge Development) **Goals: Generate new knowledge about effective approaches.**		FY 1997 Actual: $5,700,000 FY 1998 Actual: $5,708,000 FY 1999 Enacted: $2,561,000 FY 2000 Estimate: $ 0
	sites will collect data on predictor variables	

CSAP Starting Early/Starting Smart: Early Childhood Collaboration Project (SESS) (Knowledge Development) **Goal: To test the effectiveness of integrating mental health and substance abuse prevention and treatment services, for children ages birth to seven years and their families/care givers, with primary health care service settings or early childhood service settings.**		FY 1997 Actual: $6,200,000 FY 1998 Actual: $8,277,000 FY 1999 Enacted: $7,986,000 FY 2000 Estimate: $7,422,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. SAMHSA and partners execute Memoranda of Understanding *Target:* 100%	Same as FY 2000. Target expected to be achieved.	Baseline: FY 1997 Targets Determined. Update: Annually
Measure 2. Establish baseline data (Physical health, behavior, social and emotional functioning, language development *Target:* TBD	New in FY 2000. Once baselines are established, this will be a measure to report outcomes.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001
	Measure 2. Report preliminary process and outcome findings	Dropped

CSAP Youth Connect - High Risk Youth (Knowledge Development) **Goal: Prevent or reduce substance abuse by improving school bonding and academic performance, family bonding and functioning, and life management skills**		FY 1998 Actual: $6,000,000 FY 1999 Enacted: $7,000,000 FY 2000 Estimate: $7,000,000 **Note that this program is funded from the High Risk Youth budget activity.**
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*

CSAP Youth Connect - High Risk Youth (Knowledge Development) **Goal: Prevent or reduce substance abuse by improving school bonding and academic performance, family bonding and functioning, and life management skills**		FY 1998 Actual: $6,000,000 FY 1999 Enacted: $7,000,000 FY 2000 Estimate: $7,000,000 **Note that this program is funded from the High Risk Youth budget activity.**
Measure 1. Decrease substance abuse and related violence for treatment subjects relative to similar population without prevention programming *Tentative Target*: 10%	Program first included in FY 2000 plan.	Baseline: FY 2000 Targets TBD: FY 2000 Update:FY 2001
Measure 2. Sites will document models that are determined to be both effective and replicable *Tentative Target*: 60%	Program first included in FY 2000 plan.	Baseline: FY 1999 Targets TBD: FY 1999 Update: FY 2001

CSAP Managed Care Workplace Substance Abuse Prevention Initiatives (Knowledge Development) **Goal: To determine which workplace substance abuse prevention and early intervention programs are the most effective in reducing the incidence and prevalence of substance abuse**	FY 1997 Actual: $4,500,000 FY 1998 Actual: $4,594,000 FY 1999 Enacted: $4,672,000 FY 2000 Estimate: 0

FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1: Reach agreement in FY 1999 on core process and outcome measures for cross site analysis *Target*: 100%	Program first included in FY 2000 plan.	Baseline: FY 1998 Target Determined. Update: FY 1999
Measure 2: Health care utilization will increase as defined by pre-post intervention in prospective studies *Target*: TBD	Program first included in FY 2000 plan.	Baseline: FY 1999 Target TBD: FY 1999 Update: FY 2000

CSAP Clearinghouse Program (NCADI) (Knowledge Application) **Goals: To provide information about mental health to consumers, their families, the general public, policy makers, providers, and researchers**		FY 1998 Actual: $9,162,000 FY 1999 Enacted: $2,023,000 FY 2000 Estimate: $4,729,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*

CSAP Clearinghouse Program (NCADI) (Knowledge Application) **Goals: To provide information about mental health to consumers, their families, the general public, policy makers, providers, and researchers**		FY 1998 Actual: $9,162,000 FY 1999 Enacted: $2,023,000 FY 2000 Estimate: $4,729,000
Measure 1. Increase number of information requests - phone, mail, Prevline, walk-ins *Target:* 10% over FY 1997 baseline	Measure 1 (slightly reworded. Target was 5% over 1997 baseline.	Baseline: FY 1997 Target Determined. Update: Annually
Measure 1. Maintain Customer satisfaction *Target:* 85%	Measure 3 (slightly reworded). Same target.	Baseline: FY 1997 Target Determined. Update: Annually.
	Measure 2: Increase distribution of hard copy and electronic items	Dropped

CSAP Media - National Public Education/YSAPI (Knowledge Application) **Goal: To raise public awareness about substance abuse prevention issues, and to promote healthy changes in individual and group attitudes and behavior**		FY 1997 Actual: $1,000,000 FY 1998 Actual: $0 FY 1999 Enacted: $0 FY 2000 Estimate $0
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Media placements & media access *Target*: 5% over 1997 baseline	Previously reported as separate YSAPI section. Same as FY 2000. Same target.	Baseline: FY 1997 Target Determined. Update: Annually.

CSAP Centers for the Application of Prevention Technologies (Knowledge Application) **Goal: To increase the number of scientifically defensible programs, practices, and policies adapted and sustained by the state incentive grantees and their subrecipients**	FY 1997 Actual: $5,200,000 FY 1998 Actual: $6,410,000 FY 1999 Enacted: $6,449,000 FY 2000 Estimate: $6,449,000

CSAP Centers for the Application of Prevention Technologies (Knowledge Application) **Goal: To increase the number of scientifically defensible programs, practices, and policies adapted and sustained by the state incentive grantees and their subrecipients**		FY 1997 Actual: $5,200,000 FY 1998 Actual: $6,410,000 FY 1999 Enacted: $6,449,000 FY 2000 Estimate: $6,449,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1: Increase the number of technical assistance contact hours and an increase in the number of prevention technologies introduced to all SIGS & their subrecipients *Target*: 25% increase	First included in FY 2000 plan.	Baseline: FY 1998 Target Determined. Update: Annually
Measure 2: Past month substance use will decrease among youth 12-17 years old *Target*: 15% decline from baseline	First included in FY 2000 plan (YSAPI measure).	Baseline: FY 1997 Target Determined. Update: Annually.

CSAT Treating Adult Marijuana Users (Knowledge Development) **Goal: To enhance knowledge about treating adult marijuana users**		FY 1997 Actual: $1,300,000 FY 1997 Actual: $1,680,000 FY 1998 Actual: $1,844,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1: Submit two clinical intervention manuals with lessons learned *Target*: 2 manuals	Was Measure 4. Same as FY 2000.	Baseline: FY 1997 Target Determined. Update:FY 1999
Measure 2: Clients provided 12 weeks of treatment will have better outcomes than those provided 6 weeks *Target*: TBD	New in FY 2000.	Baseline: FY 1999 Target TBD: FY 2000 Update:FY 2001
	Measure 1. Final protocols from 100% of sites	Dropped
	Measure 2. Complete intervention & final data collection at100% of sites	Dropped
	Measure 3. Sites will conduct and submit data analysis	Dropped

CSAT Wraparound Services for Clients in Nonresidential Programs (Knowledge Development) **Goal: To enhance knowledge about the effects on outcomes of providing wrap around services (e.g.,child care, transportation, educational services)**		FY 1996 Actual: $1,200,000 FY 1997 Actual: $2,339,000 FY 1998 Actual: $2,005,000 FY 1999 Enacted: 0
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Coordinating Center will develop and apply statistical models *Target:* TBD	Was Measure 3. Same as FY 2000.	Baseline: FY 1999 Target TBD: FY 1999 Update: FY 2001
Measure 2. Final reports with findings, documented databases and statistical models are transmitted to CSAT, results validated *Target:* 100% of final reports	Was Measure 4. Same as FY 2000.	Baseline: FY 1996 Target determined. Update: FY 2001
Measure 3. Clients receiving wrap-around services will have better outcomes than clients who receive substance abuse treatment alone *Target:* TBD	New in FY 2000.	Baseline: FY 2000 Target TBD: FY 2000 Update: FY 2001
	Measure 1. Finalize protocol for collecting data, conducting data analysis, etc.	Dropped
	Measure 2. Complete observation study and final data collection at all clinical sites	Dropped

CSAT Treating Teen Marijuana Users (Knowledge Development) **Goal: To enhance knowledge about treating teen marijuana users**		FY 1997 Actual: $1,950,000 FY 1998 Actual: $3,200,000 FY 1999 Enacted: $3,200,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1: Clients treated with all five models will have significantly reduced marijuana use but none of the treatment will be more effective than the others	New in FY 2000	Baseline: FY 1999 Target TBD: FY 1999 Update:FY 2000

CSAT Treating Teen Marijuana Users (Knowledge Development) **Goal: To enhance knowledge about treating teen marijuana users**		FY 1997 Actual: $1,950,000 FY 1998 Actual: $3,200,000 FY 1999 Enacted: $3,200,000
Target: TBD		

CSAT Addiction Technology Transfer Centers (Knowledge Application) **Goals: Promote the adoption of best practices**		FY 1998 Actual: $7,545,000 FY 1999 Enacted: $7,545,000 FY 2000 Estimate: $7,545,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1. Individuals trained per year *Target:* 12,000	New in FY 2000	Baseline: FY 1997 Target Determined. Update: Annually
Measure 2. Develop and implement nationally recognized standards for education and training professionals *Target:* All States adopt standard by FY 2002	New in FY 2000	Baseline: FY 1998 Target Determined. Update: Annually.

OMC Managed Care Activities (Knowledge Development and Application) **Goal: Promote the availability of effective services to persons enrolled in managed care**		Funding is derived from the Knowledge Development and Application budget activity.
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1: Publication of reports on managed mental health and substance abuse services *Target*: 9 reports	Same as FY 2000	Baseline: FY 1998 Target Determined. Update:Annually
Measure 2. Provide training on managed mental health and substance abuse issues *Target*: 80% satisfaction with training	New in FY 2000	Baseline: FY 1998 Target Determined. Update:Annually
Measure 3. Reported satisfaction with their involvement in Managed Care procurement, contracting and monitoring *Target*: 10 States	Was Measure 2. Same as FY 2000	Baseline: FY 1999 Target Determined. Update:Annually

OMC Managed Care Activities (Knowledge Development and Application) **Goal: Promote the availability of effective services to persons enrolled in managed care**		Funding is derived from the Knowledge Development and Application budget activity.
Measure 4. Release and use of detailed managed mental health and substance abuse quality management and accreditation guidelines *Target:* 1/2 of the States negotiating Medicaid managed care contracts	New in FY 2000	Baseline: FY 1998 Target Determined. Update:Annually

SAMHSA GOAL 4

Program Level Measures - Data

OAS National Household Survey on Drug Use (NHSD) **Goal: To provide estimates of the prevalence of substance abuse at the national level and in the 50 States and the District of Columbia**		FY 1997 Actual: $16,792,000 FY 1998 Actual: $10,000,000 FY 1999 Enacted: $26,881,000 FY 2000 Estimate: $43,343,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1: Availability of data collection system in calendar year 1999 *Target*: 1999	Same as FY 2000	Baseline: FY 1999 Target Determined. Update:FY 2000
Measure 2: Availability and timeliness of data in calendar year 2000 *Target*: 2000	Same as FY 2000	Baseline: FY 2000 Target Determined. Update:FY 2001

OAS Drug Abuse Warning Network (DAWN) **Goal: To provide estimates of drug-related emergency department visits at the national level, and for 21 large metropolitan areas**		FY 1997 Actual: $2,771,000 FY 1998 Actual: $5,936,000 FY 1999 Enacted: $5,401,000 FY 2000 Estimate: $6,646,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1: Availability and timeliness of data *Target*: TBD	New in FY 2000	Baseline: FY 1999 Target TBD: FY 1999 Update:FY 2000

OAS Drug Abuse Services Information System (DASIS) **Goal: To provide information on the services available for substance abuse treatment in the United States, and on the characteristics of patients admitted to treatment**		FY 1997 Actual: $5,515,000 FY 1998 Actual: $6,860,000 FY 1999 Enacted: $7,586,000 FY 2000 Estimate: $9,301,000
FY 2000 Measures:	*FY 1999 Measures:*	*Status:*
Measure 1: Availability and timeliness of data *Target*: TBD	New in FY 2000	Baseline: FY 1999 Target TBD: FY 1999 Update:FY 2000

Part I - Agency Performance Plan

The Substance Abuse and Mental Health Services Administration (SAMHSA) was created on October 1, 1992. According to its authorizing legislation, the purpose of the agency is A to establish and implement a comprehensive program to improve the provision of treatment and related services to individuals with respect to substance abuse and mental illness, and to improve prevention services, promote mental health and protect the legal rights of individuals with mental illnesses and individuals who are substance abusers@. The purpose of the reorganization was to create a focus on and enhance substance abuse and mental health services programs and activities. The mission set out in the legislation was broad. However, the array of programs that the new agency inherited addressed only a part of that mission, and the budgetary climate was austere at all levels of government - Federal, State, and local.

In 1996, SAMHSA published its strategic vision, including the following mission statement:

SAMHSA=s mission within the Nation=s health system is to improve the quality and availability of prevention, early intervention, treatment, and rehabilitation services for substance abuse and mental illnesses, including co-occurring disorders, in order to improve health and reduce illness, death, disability, and cost to society.

Significant accomplishments of SAMHSA=s components may be found in each section of the budget narrative.

Relationship to the HHS Strategic Plan

SAMHSA=s programs support all of the goals of the Department of Health and Human Services Strategic Plan. SAMHSA also is responsible for the FY 1999 Secretarial initiative, APrevent Youth Substance Abuse,@ and contributes to all other Secretarial initiatives. Some of the ways in which SAMHSA contributes to the goals of the HHS Strategic Plan are as follows:

Reduce the Major Threats to the Health and Productivity of All Americans (Goal 1): SAMHSA=s substance abuse prevention and treatment activities, both through the block grants and the KD&As, directly advance the achievement of Astrategic objectives@ under Goal 1 to curb alcohol abuse (1.4) and reduce the illicit use of drugs (1.5).

Improve the Economic and Social Well-Being of Individuals, Families, and Communities in the United States (Goal 2): SAMHSA programs, including the Children=s Mental Health Program and the Starting Early/Starting Smart Program, (SESS) clearly contribute to the achievement of Goal 2.

Improve Access to Health Services and Ensure the Integrity of the Nation=s Health Entitlement and Safety Net Programs (Goal 3): By supporting States in identifying and addressing substance abuse and mental health needs through the block grants -- and in reporting on their performance through a common set of performance measures, SAMHSA promotes not only the accomplishment of Goal 3, but also intergovernmental performance-based accountability.

Improve the Quality of Health Care and Human Services (Goal 4): SAMHSA=s KD&A-funded models for substance abuse and mental health treatment improve the quality of a critical aspect of comprehensive and needed health care for Americans.

Improve Public Health Systems (Goal 5): SAMHSA=s investments in improved national and state data systems, including performance data, and its support for workforce training directly improve public health systems in the United States.

Strengthen the Nation=s Health Sciences Research Enterprise and Enhance its Productivity (Goal 6): SAMHSA=s population-based and services research on substance abuse and mental health issues directly contribute to our Nation=s health sciences research enterprise.

Long-Term Policy Goals

Three long-term policy goals summarize SAMHSA=s fundamental mission. Goals and performance indicators are drawn from SAMHSA=s proposed client outcome measures; from the ONDCP Performance Measures of Effectiveness (PME); and from the draft Healthy People 2010. SAMHSA will continue to support all of the long-term goals of the PME and Healthy People 2010 which relate to SAMHSA=s programs.

Support and contribute to the improvement of community-based systems of mental health care to increase the level of functioning and quality of life for adults with serious mental illnesses and for children with serious emotional disturbances.

Performance Indicators: Increase the percentage of adults with serious mental illness who are currently employed or engaged in productive activities; have a permanent place to live in the community; have not had contact with the criminal justice system. Increase the percentage of children with serious emotional disturbances who attend school regularly; reside in a stable environment; and have no contact with the juvenile justice system. Specific targets have not yet been established pending availability of baseline data.

Educate and enable America=s youth to reject illegal drugs as well as underage use of alcohol.

Performance Indicators: Reverse the upward trend and cut monthly marijuana use among 12 to 17-year-olds by 25 percent, from the 1995 baseline of 8.2 percent to 6.2 percent by the end of FY 2002. By 2002, reduce the prevalence of past month use of illegal drugs and alcohol by youth by 20 percent as measured against the 1996 base year. By 2007, reduce this prevalence by 50 percent. Reduce tobacco use by youth by 25 percent by 2002 and by 55 percent by 2007.

Assist States and communities by supporting and helping to improve their substance abuse prevention and treatment efforts.

Performance Indicators:

(a) Increase the percentage of adults receiving substance abuse services who are currently employed or engaged in productive activities; had a permanent place to live in the community; had no or reduced involvement with the criminal justice system; experienced no or reduced alcohol or illegal drug related health, behavior, or social consequences, and had no past month substance abuse (Specific targets have not yet been established pending availability of baseline data). By 2007, as compared to the 2001 base year, achieve for those completing substance abuse treatment programs a: 10 percent increase in full time employment (adults); a 10 percent increase in educational status (adolescents); a 10 percent decrease in illegal activity; and a 10 percent increase in general medical health.

(b) Reduce the size of the treatment gap, defined as the difference between those seeking treatment and those receiving it. By 2002, reduce the public treatment gap by at least 20 percent as compared to the 1996 base year; by 2007, reduce the gap by at least 50 percent. National data source under consideration in cooperation with ONDCP. SAMHSA will collect program level data.

SAMHSA has been fully involved in the PME effort. SAMHSA provides direct programmatic support to Goals 1 and 3 of the National Drug Control Strategy and the PME effort, and contributes to Goal 2. SAMHSA has participated in the development of the PME system for the Strategy, chairing or co-chairing each working group for every objective of Goal 1 and Goal 3, and participating in Goal 2 working groups. In addition to developmental and programmatic support, SAMHSA provides tracking data for many of the objectives of the Strategy. Refining measures, developing strategies, identifying data sources, and setting annual targets are now under discussion.

SAMHSA is the lead agency, with the National Institutes of Health, for the Substance Abuse chapter of the HHS Healthy People 2010, and for the Mental Health and Mental Disorders chapter. The draft Healthy People 2010 document is undergoing revisions prior to its completion later this year.

For SAMHSA=s three long-range goals and for the goals and objectives of the PME effort and Healthy People 2010, the intent is to establish, maintain, and if possible to accelerate a trend toward a desired target, not to set specific annual targets. Results in any one year are considered less significant than the cumulative result. In the context of the National Drug Control Strategy, the process of establishing targets under these circumstances is conceptualized as determining the Aglide path.@ Moreover, since (1) these long-range goals represent a national effort, (2) SAMHSA is allocated only a portion of the dollars needed to address these problems, and (3) there are many factors influencing the outcomes other than SAMHSA=s programs, the agency can influence only a portion of the national outcomes.

Program Goals

Over the nearly six years since its creation as a services agency, SAMHSA has worked to develop and implement a program and budget structure that is consistent with its legislatively defined mission. For FY 2000 and beyond, SAMHSA has identified four key program/operational goals, directly related to current and proposed activities and programs, which summarize the contributions SAMHSA can make to the achievement of the broader national objectives. Unlike the long-term policy goals, these operational goals reflect the outcomes of SAMHSA=s programmatic activities. The four goals unite SAMHSA=s activities, allocation of resources, budget request, and GPRA performance plan. They provide a logical framework for SAMHSA=s spectrum of programs, and are useful in developing measures for new programs.

Goal 1. Bridge the gap between knowledge and practice.

Relevant Budget Lines: Knowledge Development and Application; High Risk Youth

Performance Indicators: Prospective measures of these activities include the field=s judgment that the proposed activities are important and useful. Retrospective measures include evaluation of the quality of the products developed. A final measure of success is the significance of the results, and whether they warrant further dissemination.

SAMHSA=s legislative mandate includes conducting and coordinating demonstration projects, evaluations, service system assessments, and other activities necessary to improve the availability and quality of services. SAMHSA was established as a separate services agency in part because a variety of constituent groups perceived a need to establish a firmer link between findings developed through research programs, tested in relatively controlled environments, and the actual needs of providers, clients, and families at the point of service. In 1995, when SAMHSA held meetings around the country with providers, clients/consumers, families, and State and local officials to obtain input on strategic priorities, this issue was emphasized repeatedly as one that should be given particular priority within the agency. Providers and clients need enough information to ascertain whether a possible improvement will work in their service setting in their client population, and to determine how to go about implementing that improvement. SAMHSA=s knowledge development programs contribute to this transfer of knowledge from research into practice, in support of the agency=s services mission. The important state-of-the-art knowledge derived from these studies can have a substantial impact on client outcomes when the knowledge is disseminated and adopted.

An example of this type of program is the ACCESS program in CMHS, which has examined the impact of integrated service systems on providing services to persons who are homeless and seriously mentally ill and on improving outcomes for this population. The program was initiated in 1993 as a five-year study. While final data are not yet available, two cohorts of available data show increases for the clients served within the study in number of days housed; decreases in drug use; increases in number of days in outpatient settings; and decreases in the percentage committing a minor crime. Indications at this point are that this knowledge development program will produce significant results which will warrant further dissemination.

Goal 2. Promote the adoption of best practices.

Relevant Budget Line: Knowledge Development and Application

Performance Indicators: These activities are to be assessed, through a sampling strategy, according to changes in user practice and adoption by users.

Publication of new findings often is insufficient to change practice. To promote the adoption of best practices, SAMHSA will distribute information strategically to enhance services in communities. In addition, a variety of incentives and assistance will be provided to States, local communities, and providers. These activities help to ensure that service providers have the opportunity to implement important findings. Along with SAMHSA=s knowledge development activities, this knowledge application investment contributes toward SAMHSA=s legislative mission to improve, as well as to support, services.

An example of this type of program is the CMHS Community Action Grants (CAG) Program. This program supports adoption of exemplary mental health practices through the identification of evidence-based models that may be selected by local communities for adoption into their local systems of care. CAGs identify Exemplary Practice Models that meet objective, evidenced-based-criteria and support consensus building among key stakeholders to adopt the exemplary practice. Information about these approved exemplary practices is then made available to new sponsors of exemplary practices in other communities

Goal 3. Assure services availability / meet targeted needs

Relevant Budget Lines: Targeted Capacity Expansion; Children=s Mental Health Services; Substance Abuse Prevention and Treatment Block Grant; Community Mental Health Services Block Grant; Protection and Advocacy for Individuals with Mental Illnesses; and Projects for Assistance in Transition from Homelessness.

Performance Indicators: Results of Targeted Capacity Expansion activities are to be assessed with respect to changes in practice and client outcomes. Measures are being developed and refined by SAMHSA and the States for application to the block grants. Measures for the two formula grants already are in place, and are contained in the CMHS section of this performance plan.

Most of SAMHSA=s funding is invested in Goal 3 activities. These activities provide direct support for services, either through direct support to implement needed services within a community through discretionary grants or, more broadly, through block and formula grants to States. SAMHSA=s Targeted Capacity Expansion programs are discretionary programs specifically intended to target service gaps, community needs, or emerging problems. Special grant programs provide resources to meet these needs. Within these relatively new programs, services funded are based upon Abest practices@ models, and results are carefully evaluated. Block and formula grant programs permit States or other designated recipients to allocate resources to ensure basic access or to meet identified needs.

An example of a Targeted Capacity Expansion program is the State Incentive Grants program in CSAP, which provides incentives to States to improve collaboration among State agencies, community organizations, and other prevention groups to promote community use of scientifically defensible prevention services and policies and to optimize, redirect, and leverage use of all funding streams for prevention. First awards for this program were made in FY 1997. States have

agreed on the use of core data to be collected across sites at the State, subrecipient, and program levels. It is anticipated that the results of this program will include measurable decreases in past month substance abuse among youth. States also will document and evaluate the new or modified prevention systems that result from these grants, and do qualitative comparisons with the Aold@ prevention system.

An example of a formula grant program (other than the two SAMHSA block grants) is the mental health Projects for Assistance in Transition from Homelessness (PATH) program. Through a formula grant to each State and territory, States can provide flexible, community based services for people with serious mental illness who are homeless or at imminent risk of becoming homeless. This program was established in 1990. Data collection has been ongoing for a number of years. Measures include persons contacted, the proportion of participating agencies that offer outreach services, and the percentage contacted who become clients of the mental health system.

Goal 4. Enhance service system performance

Relevant Budget Lines: National Data Collection (funds were not appropriated to this budget line in FY 1999); 5% set-aside from the MH and SAPT block grants.

Performance Indicators: Results of these activities are to be assessed utilizing feedback from users of the data, information, or other systems.

SAMHSA also enhances service system performance through activities that support the delivery of services, such as primary data collection and reporting; support of data infrastructure development at Federal, State, and local levels; conduct of broad program evaluations; and other similar infrastructure issues. This goal relates to infrastructure issues at all levels, from broad infrastructure development efforts within the Public Health Service to small area data and information collection and analysis that can assist States in determining how to allocate their block grant allotments in order to have the greatest impact on services needs. For FY 1999 and FY 2000, SAMHSA is focusing on data issues within this goal. Future plans will address agency activities related to other aspects of infrastructure support and development. These activities currently represent a very small proportion of SAMHSA=s funding, and are carried out in support of the agency=s other programs, but growth is essential in order to support the data needs of Healthy People 2010 and the National Drug Control Strategy, as well as SAMHSA=s implementation of GPRA.

An example of SAMHSA=s activities with respect to national data collection is the expansion of the National Household Survey on Drug Abuse (NHSDA). This expansion will provide State-level estimates of the prevalence of substance abuse in the 50 States and in the District of Columbia. As a result of the expansion, it will be possible to identify States with relatively high or low rates. A second example of an ongoing activity that addresses infrastructure issues is the CMHS Mental Health Statistics Improvement Program=s Consumer Oriented Report Card, which was developed to provide feedback to consumers and family members on issues of access, appropriateness, prevention and outcome in managed care programs. Currently, it is being tested in 41 States. This report card is the only one in the field that is consumer focused, and the only one that includes outcome measures. It has been endorsed by key national mental health groups, such as the National Association of State Mental Health Program Directors, the National Alliance for the Mentally Ill, the American Association of Behavioral Healthcare, and the National Association of State Mental Health Planning Councils.

Core Set of Client Outcome Measures

SAMHSA and the Centers have developed a core set of client outcome measures for discretionary programs and projects which will begin to be applied to programs, following OMB approval, beginning in FY 1999. The goal is to implement data collection across all discretionary programs by FY 2000.

I.Summary Measure for Outcomes: Increase the proportion of the populations affected by SAMHSA programs that demonstrate improved outcomes based upon identified measures.

II. Substance Abuse Prevention Outcomes:

A. Over the past month, for those receiving services, the percent of children compared to the national average or project baseline:

1. Using substances declined
2. Strongly disapproving of substance use increased
3. Perceiving personal/health risks associated with the consequences of substance abuse increased
4. Having used substances showed an increase in age of first use
5. Expecting ever to use substances declined

B. Over the past month, the percent of parents/adults receiving services, compared to the national average or project baseline:

1. Using illegal drugs declined
2. Strongly disapproving of substance abuse/misuse increased
3. Perceiving personal/health risks associated with the consequences of substance abuse/misuse increased
4. Having used substances showed an increase in age of first use
5. Expecting ever to use substances declined

III. Mental Health and Substance Abuse Treatment Outcomes:

A. Over the past year, percent of adults receiving services increased who:

1. Were currently employed or engaged in productive activities
2. Had a permanent place to live in the community
3. Had no/reduced involvement with the criminal justice system
4. Experienced no/ reduced alcohol or illegal drug related health, behavior, or social consequences

B. Over the past year, percent of children/adolescents under age 18 receiving services increased who:

1. Were attending school
2. Were residing in a stable living environment
3. Had no/reduced involvement in the juvenile justice system
4. Had no past month use of alcohol or illegal drugs (population data limited to 12-17 year olds)

IV. Substance Abuse Prevention and Treatment Outcomes:

A. Percent increase of adults receiving services who had no past month substance abuse

B. Over the past month, percent increase of youth (population data limited to 12-17 year olds) receiving services who experienced no/reduced substance abuse related health, behavior, or social consequences

The development of client outcome measures for block and formula grants is occurring in partnership with States. It is expected that many if not most of the areas or domains included in the client outcome measures for discretionary programs will be included in a future core set of measures for the block grant. All of these domains are included in sets of indicators now being tested by States and soon to be reported on a voluntary basis as part of the block grant application.

Partners and Stakeholders

Mental health and substance abuse issues bring together a broad array of partners and stakeholders whose input is critical to the determination of agency priorities.

Partners and stakeholders include State and local governments; providers; consumers/clients of substance abuse and mental health services; family members of individuals with substance abuse or mental illness; grantees; foundations; and a variety of volunteer and other organizations that do not fall within the categories mentioned. Involved Federal agencies include, but are not limited to, all of the HHS components but especially the Health Care Financing Administration, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute of Mental Health; the Office of National Drug Control Policy; the Department of Education; the Department of Veterans Affairs; the Department of Justice; the Department of Transportation; the Department of Housing and Urban Development; and the Department of Defense.

States in particular are SAMHSA=s partners in carrying out the two largest programs, the mental health and substance abuse block grants. There are several implications of this shared responsibility in terms of GPRA implementation. The majority of resources applied to mental health and substance abuse problems are not under SAMHSA=s direct or indirect control. Therefore, accountability for outcomes for the block grants, or for the nation as a whole, is shared with States and others.

Data and Evaluation Issues

SAMHSA has made considerable progress during the past year toward obtaining needed data and assuring that there is the necessary emphasis on evaluation of agency programs. However, several major issues remain, in particular the lack of resources to collect and analyze performance data for national policy goals as well as data for assessing the performance of certain of SAMHSA=s programs.

Status of Baselines, Targets, and Update Data

Discretionary programs generally can develop measures and begin to collect baseline data in the first year after award, and set targets and begin to collect update data in the second year. Most of SAMHSA=s KD&A programs are limited to three years, with final reporting a year or more after the program is completed. Other than the expected lags between award, baseline data, target setting, and the collection and reporting of program data, SAMHSA does not anticipate difficulties in obtaining and reporting performance information for its discretionary programs.

SAMHSA also has baseline data, targets, and update data for its two mental health formula programs. While performance data are not yet available for the two block grants, SAMHSA has made considerable progress this year. The FY 2000 plan includes indicators for both the mental health and substance abuse Block Grants that have been under development, in conjunction with States, for several years. SAMHSA has now received approval for the first time from OMB to collect performance-related mental health information from States in the block grant application on a voluntary basis beginning in FY 1999. SAMHSA is continuing to work with the States, OMB, and others to reach agreement on a set of measures that will be the basis for a request for approval to collect performance-related substance abuse treatment information on a voluntary basis beginning in FY 2000; the proposed measures are included in this plan. The agency also has made considerable progress in working with the States to develop a set of substance abuse prevention measures.

Data Strategy, Challenges, Costs, and Limitations

Allocating sufficient funds for data collection and analysis in any health area always requires difficult choices, and substance abuse and mental health are no exception. Despite the role of multiple agencies and entities in collecting important data, significant gaps in the availability of data remain.

C National Data Collection

Examples of SAMHSA national surveys include the National Household Survey on Drug Abuse (NHSDA), and the Inventory of Mental Health Organizations. Data from these surveys are used for GPRA purposes to set context and to establish and/or track the agency=s broad, long-term goals that are also part of Healthy People 2010 and the ONDCP Performance Measures of Effectiveness effort. SAMHSA=s top national data collection priority is the expansion of the NHSDA to permit State-level estimates. This expansion will assist SAMHSA in providing enhanced technical assistance to States which need additional assistance as reflected by higher prevalence of substance abuse.

The collection of national data in the area of mental health and mental illness has been substantially underfunded for many years. An illustration of this problem was the inability to track a number of mental health objectives within Healthy People 2000, because it never has been possible to obtain funding for the necessary data collection activities. Another illustration is the paucity of information on the incidence and prevalence of mental illnesses and mental disorders, especially in children. Although substance abuse data efforts have been funded somewhat more generously, the ONDCP PME effort again highlights that even for substance abuse, there are major gaps in essential data. An adequate investment in national data collection is essential to the effective tracking of national results.

C Support of State Data Efforts

Examples of SAMHSA support of State data collection efforts include needs assessment activities in CSAT and CSAP, and efforts to support States in developing performance measures and identifying and collecting related outcome and other data. In order to make full use of the Block Grants as a mechanism for improving, rather than just supporting, services and other activities in States, good information must exist on the activities and services needs of the State and on the outcomes of State efforts. Traditionally, data efforts have been among the first items cut when budgets are tight. The current lack of adequate data infrastructure in States to collect and report on performance and other necessary data reflects many years of limited funding. SAMHSA=s top State data priority is support of activities to help States develop an adequate data infrastructure to permit the collection and reporting of essential data.

C Data Collection for GPRA Reporting

SAMHSA has the necessary authorities and funding to collect and report necessary data for all programs other than the Block Grants, utilizing a portion of program funds. However, for the block grants, SAMHSA lacks authority to require performance-related data. Despite this limitation, the States and SAMHSA have been working in voluntary partnership for several years to develop measures that are useful to States as well as to the Federal Government. SAMHSA has been able to use set-aside funds from each block grant to develop measures and pilot their application. The agency also should be able to obtain OMB approval to collect data on a voluntary basis for substance abuse treatment and prevention, as has been accomplished for mental health. SAMHSA has been advised by OMB that SAMHSA cannot require outcome data reporting as part of the block grant application, but must work with the States to urge them to report on a voluntary basis. OMB was, however, strongly supportive of such voluntary submission of data. A major impediment is that without infrastructure funding, there are many States that will not be able to take the essential next step of generating and reporting these data for mental health, substance abuse, or for both.

Evaluation

SAMHSA has implemented an evaluation policy that defines an integrated model of evaluation and planning. The formulation of programmatic and evaluation priorities includes consultation with the SAMHSA and Center Advisory Councils, and with other experts in the fields of evaluation and service delivery. Results from evaluations provide information useful for program planning and policy development, as the agency continues to refine its priorities and objectives. A common evaluation protocol is under development by the Centers that will ensure that the necessary evaluation information for SAMHSA=s minimum set of program performance measures is available.

Conclusion

SAMHSA has made considerable progress in its GPRA implementation efforts this year, such as inclusion of long range goals and measures, performance indicators for both Block Grants, and the general strengthening of measures for SAMHSA's programs.

Part II: Component Performance Plans

Center for Mental Health Services

Note: The table which follows lists all significant Center for Mental Health Services (CMHS) programs. Many programs, especially Knowledge Development and Knowledge Application programs, are time-limited. Some are ongoing. The table identifies the fiscal year (FY) each program began and the FY the program will be completed. Time-limited programs generally are first reported in the GPRA plan section of the Budget Submission once baselines have been determined, targets set, and update data are being collected. Final reporting of these programs generally occurs one to two years following completion of the program.

Summary information on how proposed or newly initiated programs are to be measured may be found in the budget narrative section of the Budget Submission.

		First Funded	Completed	First Reported
Current Activities				
Goal 3: Block/Formula Grants/TCE				
Childrens MH			Ongoing	
P&A			Ongoing	
PATH			Ongoing	
MHBG			Ongoing	
Goals 1 and 2: Knowledge Development and Knowledge Application				
ACCESS		FY 1993	FY 1999 FY 2000	
Homelessness Prevention		FY 1996	FY 1999 FY 2000	
Supported Housing		FY 1997	FY 2000 FY 2001	
HIV/AIDS Education I		ongoing	ongoing	FY 2000
HIV/AIDS Services Demo	FY 1994	FY 1998	FY 1999	
AIDS High Risk		FY 1997	FY 2001 FY 2002	
Employment (EIDP)		FY 1995	FY 2000 FY 2001	
Managed Care		FY 1996	FY 1999 FY 2000	
Community Action I		FY 1997	FY 1998 FY 1999	
Criminal Justice		FY 1997	FY 2000 FY 2001	
Starting Early/SS		FY 1997	FY 2001 FY 2002	
KEN		FY 1995	ongoing	FY 1999
Consumer Services		FY 1998	FY 2002 FY 2003	
Elderly Primary Care		FY 1998	FY 2002 FY 2002	
Community Action II		FY 1998	FY 1999 FY 2000	
Women and Violence		FY 1998	FY 2003 FY 2004	
HIV/AIDS Outcome, Adherence		FY 1998	FY 2002 FY 2003	
HIV/AIDS Education II		FY 1998	FY 2002 FY 2003	
Native American Children		FY 1998	FY 2001 FY 2003	
New Activities				
Consumer & Supporter TA Centers	FY 1999	FY 2001		
School-based Violence (Multiagency)		FY 1999	FY 2001	

School-based Violence (Action Grants)	FY 1999	FY 2001
Alaska	FY 1999	FY 2000
Community Action Phase I	FY 1999	ongoing
Homeless Families	FY 1999	FY 2004
Family & Consumer Network	FY 2000	ongoing
HIV/AIDS Continuum of Care	FY 2000	FY 2003

Goal 3: Assure services availability/Meet targeted needs

a. Community Mental Health Services Block Grant

Goal: To improve community based systems of care in order to increase the level of functioning and quality of life for adults with serious mental illnesses and for children and youth with serious emotional disturbances.

Measures: Standard SAMHSA outcome measures will be applied to this program. Pilot baseline data for outcomes will be available in FY 1999. Targets will be set at that time. The Block Grant Program has made considerable progress in developing program performance indicators, in collaboration with the States. A set of access, quality, and outcome measures has been approved by OMB for implementation on a voluntary basis in FY 1999, as part of the block grant application. In addition, ten States will be engaged in a 3 year pilot to test the feasibility of a national set of 28 performance indicators. These indicators are heavily weighted toward outcome assessment. Baselines will become available for these output and outcome measures in the fall of 1999.

The full array of indicators is as follows:

Criterion 1: Comprehensive Community Based Mental Health System.

ACCESS INDICATORS

- Percentage of SMI persons (or SED persons or their parents) receiving services who rate access to care positively;
- Number of persons with SMI (or SED) who are receiving case management services;
- Number of persons with SMI (or SED) who are receiving housing services;
- Number of persons with SMI who are receiving employment services;
- Number of admissions to state and county hospitals among persons with SMI (or SED);
- Number of patients-in-residence in state and county hospitals among persons with SMI (or SED);

APPROPRIATENESS/QUALITY INDICATORS

- Percentage of SMI population (or SED persons or their parents) receiving services who rate the quality and appropriateness of care positively;
- Increase percentage of SMI population (or SED persons or their parents) receiving services who positively rate respect and caring by their providers;
- Increase percentage of SMI population who are actively involved in decisions regarding their own treatment;
- Percentage of parents of children and adolescents who are in the SED population who are actively involved in decisions regarding their child's treatment;
- Percentage of persons discharged from psychiatric inpatient care who receive a follow-up, face-to-face visit within seven days of discharge;
- Percentage of persons discharged from psychiatric emergency care who receive a follow-up, face-to-face visit within seven days of discharge;
- Percentage of SMI population who are receiving "supported housing" services;

- Percentage of SMI population who are receiving "supported employment" services;
- Percentage of SMI population who are receiving "assertive community team" services;
- Percentage of SMI population who receive a physical health examination annually;

OUTCOME INDICATORS

- Percentage of SMI population (or SED persons or their parents) receiving services who report positive outcomes of care (or for whom positive changes are reported);
- Percentage of SMI population for whom there are positive changes in employment;
- Percentage of SED population for whom there is improvement in school functioning;
- Percentage of SMI population for whom there are positive changes in living situation;
- Percentage of SMI population for whom there are improvements in personhood, hope, and recovery;
- Percentage of SMI/SED population for whom there are positive changes in level of functioning;
- Percentage of SMI/SED population for whom there is reduced distress from the symptoms of mental illness;
- Percentage of SMI/SED population for whom there is either no impairment or reduced impairment from substance abuse;
- Percentage of persons served with SMI who experience adverse outcomes of mental health services;
- Percentage of persons readmitted to psychiatric inpatient care within 30 days of discharge.
- Percentage of SMI population who spend one or more days in a jail or prison.

Criterion 2: Estimates of Prevalence and Treated Prevalence and Mental Health Systems Data.

POPULATION ACCESS INDICATORS

- Percentage of adults with serious mental illness who receive publicly funded services;
- Percentage of children with serious emotional disturbance who receive publicly funded services.

SPECIAL POPULATION INDICATORS

For all illustrative indicators shown under Criterion 1 and 2 above or others that states may develop, estimation of performance on the same indicators for significant sub-populations, including breakouts by

- Gender
- Ethnicity
- Race
- Sub-state geographic areas
- For Adults, age sub-groupings
- For Children & Adolescents, age sub-grouping

Criterion 3: Targeted Services to Homeless and Rural Populations.

- Percentage of homeless persons with SMI (or SED) and who receive mental health services.
- Percentage of rural persons with SMI (or SED) and who receive mental health services.
- For all, relevant, illustrative indicators shown under Criterion 1 and 2 above or others that states may develop, estimation of performance on the same indicators for persons with SMI/SED and homeless and for persons who are SMI/SED and living in rural areas of the state.

Criterion 4: Management Systems.

- Proportion of state mental health block grant funds allocated to innovative programs;
- Percentage of SMHA-controlled expenditures for community programs of total SMHA-controlled expenditures;
- Mental health expenditures *per capita*;
- Mental health expenditures *per person served*;

- Extent of involvement of consumers and families in (a) policy development, (b) planning, and (c) quality assurance/monitoring at the statewide level, the local mental health authority level, and the provider level.

FOR MENTAL HEALTH, MEDICAID MANAGED CARE PLANS:

- Number of persons with SMI (or SED) and who are enrolled in Medicaid managed care for health and mental health services (integrated plan) or mental health/behavioral health services only (carve out plan);
- *Per member per month* plan premium rate (statewide average);
- Percent of total plan expenditures attributable to (1) Medical loss, (2) Administrative loss, and (3) Net Profit/loss.
- Extent of involvement of consumers and families in (a) policy development, (b) planning, and (c) quality assurance/monitoring within the managed care plan.

Criterion 5: Integration of Children's Services.

- Percentage of children with SED who are placed out-of-home (*e.g.*, foster care, residential home, juvenile detention).
- Percentage of children with SED who are attending school regularly;
- Percentage of children with SED who are also receiving special education services;
- Percentage of children with SED who are also clients of the juvenile justice system;
- Percentage of children who are SED who are also receiving substance abuse services.

Measure 1: Three overarching SAMHSA outcome indicators for children with serious emotional disturbance and three overarching SAMHSA outcome indicators for adults with serious mental illnesses will be reported as part of the FY 1999 block grant applications, as follows: Increase the percent of adults with serious mental illness who are employed, are living independently, and have had no contact with the criminal justice system; and the percent of children with serious emotional disturbance who attend school regularly, reside in a stable environment, and have no contact with the juvenile justice system.

FY 1999 Target: Baseline data will be available early in FY 2000.
FY 2000 Target: To be developed once baseline data are available.
Update Date: To be available in FY 2001.

Data Source/Validity of Data: On a voluntary basis information will be solicited in a nondirective format in the OMB approved Block Grant Application, 1999-2000. Initial experience in FY 1999 will identify need for improvements to data infrastructure. Data will be reported by States indicating sources within states.

Measure 2: Ten States will pilot 28 performance indicators between FY 1998 - FY 2001.

Rationale: In the FY 1998 pilot, ten states began piloting 28 performance measures State wide. By FY 2001, this pilot work will be completed. This set of 28 performance measures has been identified through the 5 State Feasibility Study funded in FY 1997. Results support the feasibility of piloting a common set of performance indicators for the States. The 28 OMB-approved performance measures constitute a sample menu for inclusion in the FY 1999 Block Grant Application. OMB has designated the overall format as voluntary and measures are provided as a sample menu for selection, not as a blueprint or a requirement; states may also develop and use additional indicators which are unique. The conceptual foundation for the 28 indicators is the MHSIP Consumer Oriented Report Card for managed behavioral healthcare, which is now being tested in 41 States.

FY 1999 Target: Baseline data will be available early in FY 2000
FY 2000 Target: To be developed once baseline data are available.
Update Date: To be available in FY 2001.

Data Source/Validity of Data: State Mental Health systems will collect this data each year. Data accuracy will be assessed in the Pilot. States included in the first phase (5 State Feasibility Study) will continue to collect this data. The Five State Study documented the feasibility of piloting these 28 indicators in a comparable way across States.

b. CMHS Comprehensive Community Mental Health Services for Children and Their Families

Goal: To successfully implement Asystems of care@ for children with serious emotional disturbance and their families in grantee sites; and to improve outcomes for children and their families served in these systems of care. Empirical evidence suggests that system-of-care programs increase the access that children with serious emotional disturbance and their families have to a wide array of services as compared to programs delivering services as usual. There is also preliminary evidence from the multisite evaluation of the CMHS comprehensive program that outcomes for children and their families improve in CMHS projects that apply the system-of-care approach.

Measures: Standard measures will be applied to this program, but existing measures as modified below will continue to be utilized as well. Note that some process measures included in the FY 1999 plan have been deleted or recategorized. Former measure 3, Increase Referrals from Juvenile Justice, has replaced former Joint Contribution of Mental Health Service Components of Other Non-Mental Health Child-serving Agencies as an indicator of Measure 1, referred to as Increased Interagency Collaboration. Also note that Measure 6, Increase Stability of Living Arrangements is now listed as Measure 5. An indicator for Measure 3, Improved Child Outcomes, has been added, namely, Increase the Children with Law Enforcement Contacts at Entry Who Have no Law Enforcement Contacts After Six Months. These changes were mostly made to reflect guidance to reduce the number of measures in the GPRA plan. Inasmuch as FY 1998 data are not yet available and the FY 1999 targets were very aggressive with respect to improved results, CMHS has retained the FY 1999 targets for FY 2000.

Progress report: The increase in the budget for this program has permitted funding more sites. Evaluation, technical assistance, and communication activities are an integral part of this program. Success to date is documented in the following preliminary results. Based on data collected through August 1997, preliminary findings show notable improvements for children who are in services for at least six months. For example, using standard measures, evaluation indicates that after six months:

- levels of functional impairment decreased by 20%,
- average or above average grades increased by 13%,
- infrequent school attendance reduced by 42%,
- decrease in law enforcement contacts for 47% of children with law enforcement contacts at intake,
- decrease to Aone living arrangement@ among 49% of children with multiple arrangements at intake.

Measure 1: Increase Interagency Collaboration as reflected below

Rationale: Collaboration across human service agencies is a critical component of the system of care approach. It helps to insure that the Awhole@ child will be served, funding resources for the treatment needs of the child will be maximized, and the opportunity for the child to have the optimum set of services available will increase. The set of indicators below examines the degree to which process features of the system-of-care approach result in increased interagency collaboration.

Measure	FY 1997 Baseline	FY 1998 Target	FY 1999 Target	FY 2000 Target
Increased Interagency Collaboration	75%	Referrals from other non-MH agencies for MH services will increase by 5%	Such referrals will increase by 10%	Such referrals will increase by 10%
	9%	Referrals from juvenile justice programs will increase by 10%	Such referrals will increase by 12%	Such referrals will increase by 12%
	40%	Case records that reflect cross-agency treatment planning will increase by 5%	Such case records will increase by 10%	Such case records will increase by 10%

Data Sources/Validity of Data: Data are derived from sources such as document reviews, structured and semi-structured interviews, and observations. Some of these data are collected prior to and during annual sites visits, and some are collected from a multisite longitudinal outcome study.
Progress report: Data are being analyzed.

Measure 2: Decrease Utilization of Inpatient/Residential Treatment by 20% of FY 1997 base, as measured by average days in facility.

Rationale: Children with serious emotional disturbance have historically been observed in inpatient/residential treatment programs because of a lack of community-based systems of care. Reducing reliance on residential facilities while at the same time creating service options within the community will demonstrate the development of community-based systems of care.

FY 1997 Baseline: 265 days
FY 1998 Target: Decrease of 10% of FY 1997 base in inpatient/residential days.
FY 1999 Target: Decrease of 20% of FY 1997 base in inpatient/residential days.
FY 2000 Target: Decrease of 20% of FY 1997 base in inpatient/residential days.

Data Sources: Data are derived from site-specific document reviews. These data are collected prior to and during annual site visits.

Progress report: Data are being analyzed.

Measure 3: Improve Child Outcomes as reflected below

Rationale: Studies have shown that school attendance correlates positively with overall school performance. There are also strong expectations that law enforcement contacts are reduced among children served through systems of care.

Measure	FY 1997 Baseline	FY 1998 Target	FY 1999 Target	FY 2000 Target
Improved Child Outcomes	70% of time in school	Increase by 5% the number of children attending school 75% of the time.	Increase by 10% the number of children attending school 75% of the time.	Increase by 10% the number of children attending school 75% of the time.
	47% of children with law enforcement contacts at entry have no such contacts after six months	Increase to 52% the children with law enforcement contacts at entry who have no such contacts after six months	Increase to 57% the children with law enforcement contacts at entry who have no such contacts after six months	Increase to 57% the children with law enforcement contacts at entry who have no such contacts after six months

Data Sources/Validity of Data: Data are derived from document reviews. These data are collected prior to and during annual site visits. Some of the data are also collected from a multisite core longitudinal study.

Progress report: Data are being analyzed.

Measure 4: Increase Level of Family Satisfaction with Services by 10% over FY 1997

Rationale: Family involvement is a cornerstone of systems of care. Increasing the satisfaction rate of families receiving services shows that the level and type of care are those the Acustomer@ desires.

FY 1997 Baseline: 70%
FY 1998 Target: Increase of 5% over FY 1997 baseline.
FY 1999 Target: Increase of 10% over 1997 baseline.
FY 2000 Target: Increase of 10% over 1997 baseline.

Data Source/Validity of Data: Data from two instruments measuring satisfaction outcomes will be collected: Family/Caregiver Satisfaction and Youth Satisfaction. These instruments were adapted from the work of Professor John Burchard at the University of Vermont. Items have been added to specifically address issues of cultural competence, and family-centered attributes which are hallmark characteristics of the system of care. The strength of this dual approach (youth and caregiver) is that it provides numeric values to the experiences of children and families so that it will be possible to compare quantitative data yielded from the satisfaction scales with qualitative data gathered through interviews and case studies conducted with children and families.

Progress report: Data are being analyzed.

Measure 5: Increase stability of living arrangements by decreasing the number of children having more than one living arrangement *after 6 months* in services by 25%

Rationale: Stability of the living arrangement is a key outcome of quality and comprehensiveness of services. It is a crucial condition for child development and for an acceptable family environment.

FY 1997 Baseline: 76% had more than one living arrangement after 6 months in services.
FY 1998 Target: Reduce by 10% over FY 1997 baseline.
FY 1999 Target: Reduce by 20% over 1997 baseline.

FY 2000 Target: Reduce by 25% over 1997 baseline.

Data Source/Validity of Data: Data are derived from an instrument entitled Residential Living Environments and Placement Stability Scale, developed by the Pressley Ridge School, Pittsburgh, PA, in order to operationalize the construct of restrictiveness. Restrictiveness was defined as limits placed on freedom of movement or choice by a physical facility, by rules and regulations, and by conditions of entry or departure. This scale incorporates an adapted version of the Restrictiveness of Living Environments Scale (ROLES) developed by Hawkins and colleagues (1992) with a Placement Stability Scale. Stability of placements is assessed by the number of days spent in each residential setting and the number of total placement changes over a specified data collection period.

Progress Report: Data are being analyzed.

c. CMHS Protection and Advocacy for Individuals with Mental Illness (PAIMI) - Services Formula Grants

Goal: Through advocacy activities, the PAIMI Program will reduce the incidents of abuse, neglect, and civil rights violations of individuals with mental illness who are placed in residential treatment and care facilities.

Measures: Some measures currently used were set out in the FY 1999 GPRA Performance Plan. The the number of clients served has been narrowed to focus on the number of abuse complaints. The measures were developed through an interagency effort (Administration on Developmental Disabilities (DHHS/ADD), the Department of Education, Rehabilitation Services Administration (RSA), and the Center for Mental Health Services (CMHS)) and are applicable to related protection and advocacy program activities administrated by other federal agencies. These measures will also be used in subsequent years. Interagency collaboration on the refinement, testing, and implementation of these performance measures will continue through FY 1998 and into FY 1999.
The data sources for all measures are the annual Program Performance Review (PPR) and Advisory Council (AC) Reports submitted by each of the 56 P&A systems in December. The information provided in these reports is generally reliable.

Measure 1: At least 9,000 complaints of abuse will be addressed by State PAIMI systems.
Rationale: Of the 23,957 complaints concerning abuse, neglect and rights violations PAIMI programs addressed in FY 1998, the number of abuse cases has increased 36 percent. The majority of these abuse cases include failure to provide mental health treatment, physical assault, inappropriate or excessive restraint/seclusion, failure to provide medical treatment and inappropriate or excessive medication. In addition, there were numerous incidents involving mental health patients who died while under treatment in State hospital facilities. State P&A investigations into these highly publicized deaths found that the treatment facility staff used either excessive physical restraint or provided inadequate medical care.

FY 1997 Baseline: 8360 abuse complaints were addressed
FY 1998 Baseline: 8500 abuse complaints were addressed
FY 1999 Target: 9000 abuse complaints will be addressed
FY 2000 Target: 9000 abuse complaints will be addressed

Measure 2: Maintain at 160,000 the number of individuals attending public education and/or constituency training activities and public awareness activities offered by the PAIMI programs.

Rationale: Expansion of outreach services, the provision of advocacy training to consumers and distribution of information generally on such topics as disability rights, consumer self-advocacy, the PAIMI Act, and State P&A systems will increase the general public awareness and general understanding of the availability of PAIMI services.

FY 1997 Baseline: 150, 916 individuals attended public education and/or constituency training and public awareness activities.
FY 1998 Target: Increase to 155,000 the number of individuals (Target revised upward).
FY 1999 Target: Increase to 160,000 the number of individuals (Target revised upward).

FY 2000 Target: Maintain at 160,000 the number of individuals (Target revised upward).

Measure 3: Maintain at 70% the percentage of priorities and goals assessed by the PAIMI Advisory Council to have made substantial progress or to have been achieved.

Rationale: This measure assesses the performance of the PAIMI programs in accomplishing their goals and objectives.

FY 1997 Baseline: Approximately 70 percent of priorities and goals had substantial progress or were achieved.
FY 1998 Target: Maintain 70% progress on priorities and goals.
FY 1999 Target: Maintain 70% progress on priorities and goals.
FY 2000 Target: Maintain 70% progress on priorities and goals.
FY 2001 Target: Maintain 70% progress on priorities and goals.

Measure 4: Increase of substantiated incidents of abuse, neglect, or rights violations reported by clients which are favorably resolved.

Rationale: This measure assesses the performance outcome of a PAIMI program's activities in favorably resolving complaints from individuals.

FY 1999 Baseline: To be determined after baseline data are collected. Anticipated at end of second quarter in FY 1999.
FY 1999 Target: To be developed.
FY 2000 Target: To be developed.
FY 2001 Target: To be developed.

d. CMHS Projects for Assistance in Transition from Homelessness (PATH) - Services Formula Grants

Goal: To provide services that will enable persons who are homeless and have serious mental illnesses to be placed in appropriate housing situations and engage them with formal mental health treatment and systems so as to improve their mental health functioning.

Measures: This program will transition to new measures; existing measures may also be used.

Program Update/Performance Report: PATH programs have been successful in targeting assistance to persons who have the most serious impairments. Among all clients who reported PATH-funded services in 1996, nearly 36% had schizophrenia and other psychotic disorders. Another 37% had affective disorders, including severe depression and bipolar disorder. At least 66 % had co-occurring serious mental illnesses and alcohol and substance use disorders. At the time of first contact with providers, half of all clients living in the streets, in shelters or in temporary housing had been homeless for more than 30 days. Despite the fact that they have multiple and complex needs and may be difficult to reach, 36% of the homeless individuals contacted through PATH-funded outreach were eventually engaged in some type of services.

Measure 1: Increase to 115,000 the number of persons contacted relative to the population in need

FY 1996 (Baseline)	FY 1997 (Projected Baseline)	FY 1998 (Projected Baseline)	FY 1999 Target	FY 2000 Target
118,000/600,000	80,000/600,000	92,000/600,000	102,000/600,000	115,000/600,000

Discussion: A person contacted is someone, not necessarily a PATH client, who meets with a PATH funded staff person providing outreach services. Some persons contacted are not willing to accept other services during the reporting period;

others are not eligible, usually because they do not have a serious mental illness. The number of persons a PATH funded provider contacts relative to need is a measure of impact. Thus, in FY 1996, the PATH program contacted about 20 percent (118,000) of the estimated eligible population.

The PATH program experienced a 32 percent decrease of funding from $29.6 million in FY 1995 to $20 million in FY 1996. Because most States programs have elected to use their annual PATH funds on an award start date that occurs late in the fiscal year, a possible decrease in the number of persons contacted will not be statistically evident until FY 1997 data are compiled. The FY 2000 budget increase would enable PATH funded programs to contact additional persons. This increase is reflected in the target for the FY 2000 GPRA performance plan, but the funding increase actually reaches programs late in FY 2000. Therefore, the effects of the budget increase are most evident in FY 2001 data, which are not reported until FY 2002.

Data Source/Validity of Data: The source of the data on the population in need is derived from national estimates of the number of persons who are homeless, applying to that number, based on studies in specific locations, an estimated percentage of homeless persons who have serious mental illnesses. The quality of the data on the number of persons contacted varies. To improve the quality, the PATH program will, after consultation with State PATH contacts, formulate and distribute a definition of Aperson contacted.@ Other quality control measures also are expected to improve data collection and reporting, and may result in subsequent revision of GPRA targets.

Measure 2: At least 80% of participating agencies offer outreach services

Discussion: Outreach is the most frequently provided PATH-funded service. The Center for Mental Health Services will encourage States to increase their funding for outreach services. As the federal PATH appropriation has decreased, the strategy of using PATH funds to connect the eligible population with existing, rather than additional community resources, is even more important. The challenge for local providers will be to maintain outreach services at close to current levels rather than offer later stage services whose availability may have decreased as a result of reduced resources in affiliated non-PATH programs. A $31 million appropriation will enable the percentage of participating agencies offering outreach services to increase from at least 70 percent to at least 80 percent.

FY 1996 Baseline: 82%
FY 1997: Data collected; to be released in mid-1999.
FY 1998 Target: 70%
FY 1999 Target: 70%
FY 2000 Target: 80%

Data Source/Validity of Data: The source of the information is data that States submit annually to CMHS. Since the sources of the State data are the local agencies that provide the services, the quality of the data is very good.

Measure 3: Maintain the percentage of persons contacted who become enrolled clients at 30% or greater

Discussion: Most local PATH funded agencies provide outreach services. In fact, PATH funds are often the only monies available to communities to support outreach to, and engagement of, clients and their transition to mainstream services. The process of outreach requires skill in gaining the trust of persons who, in many cases, are reluctant to accept help. In FY 1996, PATH providers successfully enrolled 36 percent of persons contacted as clients. In most cases, they provided for, or arranged to meet immediate needs of clients, often found temporary or longer term shelter and arranged for mental health treatment.

However, not all persons contacted, even those willing to accept help, were eligible for PATH-funded services. In many cases, as mentioned above, it may have turned out that the person contacted, after further assessment, did not have a serious mental illness. In these cases, the person was assisted by the PATH-funded agency, but through services funded by non-PATH sources, or was referred to another agency.

As PATH appropriations have decreased and funds for related resources that outreach workers can offer are decreased, the incentive for homeless persons with serious mental illnesses to accept outreach services will decrease. Outreach workers will need to make increasing use of existing resources to engage and further assist potential clients. A $31 million appropriation in FY 2000 will enable PATH funded programs to enroll at least 33 percent, rather than the previous minimum of 30 percent, of persons contacted. While this expected increase is reflected in the target for the FY 2000 GPRA performance plan, the funding increase will actually reach programs late in FY 2000. Therefore, the effects of the budget increase are most evident in FY 2001 data, which are not reported until FY 2002.

FY 1996 Baseline: 36%
FY 1997 Baseline: Data collected; to be released in mid-1999.
FY 1998 Target: 30%
FY 1999 Target: 30%
FY 2000 Target: 33%
Data source/Validity of Data: The sources of the data are States which receive these data from local providers. The data on Apersons contacted@, as mentioned above, are of varying quality. Data on Aclients@ are of good quality. A working definition of Aclient@ is provided to States and local PATH funded agencies and is customarily followed.

Goal 1: Bridge the gap between knowledge and practice

a. Access to Community Care and Effective Services and Supports (ACCESS); Cooperative Agreement Demonstration Program

Goal: This program is examining the impact of integrated service systems on providing services to persons who are homeless and seriously mentally ill and on improving outcomes for this population.

Measures: This program is nearing completion. Two of the three measures from the FY 1999 GPRA Performance Plan will not be reported in FY 2000. Measure 1, which was a process measure involving the percent of integration strategies implemented, has been dropped in response to guidance indicating that the overall number of measures, particularly process measures, should be reduced. The new Measure 1 on level of systems integration was added to improve performance monitoring. It is maintained in the Plan but data will only be reported for FY 1999 and FY 2001 because it is collected biennially.

Program Update/Performance Report: An evaluation is being conducted that has both a systems-level and client-level focus. The system level evaluation will document the implementation process of the systems integration approaches, identify implementation barriers and facilitators, and measure system outcomes. The client level evaluation will determine whether systems integration efforts result in improved service delivery, improvements in mental health, substance abuse and health status, rehabilitation, quality of life and permanent exit from homelessness. A sixth year of data collection has been added to examine whether systems integration efforts are sustained and client outcomes continue to improve beyond Federal funding. Results will be ready for full reporting in FY 2001.

Measure 1: Maintain level of systems integration at .74 in FY 2000. The data for this measure are collected biennially; collections are for reporting in FY 1999 and FY 2001.

Rationale: ACCESS predicts that the level of systems integration at each of the project sites will increase over 4 points of time during the life of the program. The level of systems integration is being tested as a predictor of services outcomes.

FY 1994 Baseline:	Experimental Sites = .43	Comparison Sites = .45
FY 1996 1st mid-point:	Experimental Sites = .57	Comparison Sites = .58
FY 1998 2nd mid-point:	Experimental Sites = .66	Comparison Sites = .57
FY 1999 target:	Experimental Sites= .74	Comparison Sites = .57

FY 2000 target: Experimental Sites = .74 Comparison Sites = .57

Discussion: Systems integration is defined as the proportion of agencies that have multiple service links with the ACCESS grantee. Service links are defined as client referrals, exchange of funds, information flow and coordination. This measure ranges from 0 to 1 with 1 indicating the highest level of systems integration. The measures of systems integration that were collected at baseline (FY 1994) and at the two mid-points (FY 1996 and FY 1998) indicate that over time, the experimental sites were able to develop more integrated service systems than the comparison sites. It is expected that the level of systems integration will continue to increase in the experimental sites and remain constant or decrease in the comparison sites. The final measure of systems integration, which will be collected during FY 2000, is expected to be approximately .74 for the experimental sites and .57 for the comparison sites.

Data Source/Validity of Data: The data collection and analysis are included in the inter-organizational study to be done by the contractor. High validity is expected due to the experience of the contractor and the established methodology.

Measure 2: Improvements in client outcomes at twelve months for cohort 4 will be equal to or greater than the improvement at twelve months for cohorts 1, 2, and 3.

Rationale: Enhancing clinical services in both the integration and comparison groups should result in improvements in client outcomes. Future analyses will compare changes in access to services and supports between the integration and comparison sites to determine the extent to which an integrated services system has an impact on persons who are homeless with serious mental illness.

First Cohort (data available in FY 1996): 12 month follow up data on the first cohort of ACCESS subjects shows: (1) number of days housed increased by 600%; (2) total number of days of drug use decreased by 45.6%; (3) number of days in outpatient psychiatric services increased by 19.76%; and (4) percentage committing a minor crime decreased by 45.5%.

Second Cohort (data available in FY 1997): 12 month follow up data on the second cohort of ACCESS subjects shows: (1) number of days housed increased by 528.6%; (2) total number of days of drug use decreased by 37.6%; (3) number of days in outpatient psychiatric services increased by 49.5%; and (4) percentage committing a minor crime decreased by 50%.

Third Cohort (data available in FY 1998): 12 month follow up data on the third cohort of ACCESS subjects shows: (1) number of days housed increased by 613.8%; (2) total number of days of drug use decreased by 14.3%; (3) number of days in outpatient psychiatric services increased by 30.0%; and (4) percentage committing a minor crime decreased by 41.7%.

Fourth Cohorts (data available in FY 1999): Equal to or exceed the above outcomes.

Data Source/Validity of Data: The subcontractor will collect repeated measures with standardized instruments. High validity and reliability are expected.

b. CMHS Employment Intervention Demonstration Program (EIDP)

Goal: The goal of this program is the development of knowledge of the most effective approaches for enhancing competitive employment for adults with severe mental illness.

Program Update/Performance Report: Enrollment is now completed at each site and two year follow up data will be collected for all participants by the end of this program. Because employment is episodic, results regarding long term outcomes are necessary. Preliminary data indicate that persons with serious mental illness are employable - over half of

those receiving services for 9 or more months have held at least one job and work productivity remains high. To date, integrated approaches show higher rates of locating jobs than do nonintegrated approaches.

Measure 1: Employment outcomes will significantly improve at intervention projects.

Rationale: Standard research evaluation procedures (i.e., hierarchical linear models (HLM) for multi site data analyses) will be followed and reviewed by experts within and outside the EIDP. The project will evaluate numbers of days employed, pay, tenure, and characteristics of jobs.

FY 1998 Baseline: Preliminary analyses of first two years of program data completed by late FY 1999.
FY 1999 Target: Preliminary multi variate (HLM) analyses conducted on work outcomes in first three waves of data (baseline, 6 months, 12 months)
FT 2000 Target: Multi variate (HLM) analyses conducted on work outcomes across 5 time points (baseline, 6 months, 12 months, 18 months, 24 months)

Data Source/Validity of Data: Reliability of data is assessed through standard research procedures. Data are collected within the program and analyses are performed by the coordinating center.

Measure 2: Development of direct costs for various models of interventions and models of usual services.

Rationale: Program costs are needed in optimal program planning. A descriptive analysis of individual site program costs can provide useful information to those considering model implementation.

FY 1998 Baseline: Site by site audit of each program's ability to provide and document cost data completed by end of FY 1998.
FY 1999 Target: Detailed descriptions of each site's documented program costs prepared by late FY 1999.
FY 2000 Target: Analysis of data on each site's program costs prepared by late FY 2000.

Data Source/Validity of Data: Detailed service utilization data are collected within the programs and the coordinating center will collect and analyze cost data from each site.

Goal 2: Promote the adoption of best practices

a. CMHS National Mental Health Services Knowledge Exchange Network (Knowledge Application)

Goal: To provide information about mental health via various media to users of mental health services, their families, the general public, policy makers, providers, and researchers. The dissemination of timely, organized, and easily accessed information is crucial to the informed use of services and policy decisions.

Measures: The first measure from the FY 1999 GPRA Performance Plan, as modified below, will be used during the development of a second measure. Targets for the new measure will be reassessed as data are reviewed.

Program Update/Performance Report: Activity is greatly increased. Advancement in technology has made the bulletin board service (bbs) not a useful approach to dissemination and plans tentatively are for its phase out in FY 1999.

Measure 1: Increase the usefulness of KEN information.

Rationale: Usefulness will be assessed by a review of comments received in response to a KEN user satisfaction survey.

FY 1999 Baseline: User assessment of the usefulness of KEN information in FY 1999.

Measure 2: Increase by 10% each year the number of requests for brochures, information kits, and publications; the number of written and telephone inquiries; and the number of connects to the World Wide Web site.

Rationale: These data provide a concrete measure of successful performance. The increase in use of KEN indicates the need for and usefulness of this information and the format.

	INQUIRIES	WEB HITS	BBS
FY 1996	10,324	11,108*	39,026
FY 1997	26,603	152,355	91,033
FY 1998	32,058	105,175	216,012

* Web service from April to September 1996

FY 1998 Baseline: For FY 1998, there were 54,000 hits, approximately 12,000 inquiries, and 61,000 bbs connections.
FY 1999 Target: Maintain or exceed the FY 1998 hits and inquiries
FY 2000 Target: Exceed the FY 1998 hits and inquiries

Data Source/Validity of Data: Monthly reports from KEN contractor are anticipated to have high validity.

b. Community Action Grants (CAG) for Service Systems Change

Goal: To identify exemplary practices for mental health services to persons with serious mental illness and to accomplish adoption of such practices in as many communities as possible.

Measures: FY 1999 data are not yet available to develop the FY 2000 targets. Baseline data will be available in FY 2000. This information is necessary before the target percentages can be adjusted in future years.

Program Update/Performance Report: In FY 1997, twenty Phase I Community Action Grants were awarded. In FY 1998, the Basic Phase I Action Grant Program continues to target children with serious emotional disturbances and adults with serious mental illness who may also have co-occurring disorders. In addition to this Basic Program, a joint effort among SAMHSA=s Center for Substance Abuse Prevention, Center for Substance Abuse Treatment, and CMHS targets Hispanic communities to support the adoption of exemplary practices for Hispanic adults and adolescents with mental health and/or substance abuse problems. Data for grants funded in September 1997 will be available in March 1999.

Examples of activities to date include:

1. CAGs in rural South Carolina and the City of Berkeley (California) are working to reach agreement on adopting the Program for Assertive Community Treatment (PACT) - a proven and effective clinical team approach for the seriously mentally ill person. In 1997, CMHS funded the development of the standards for PACT and shortly thereafter the State of Texas mandated PACT to become standard practice and Acover every foot in the great State.

2. Pennsylvania, California, Maine, Washington, D.C., and New York are developing consensus to implement effective Awrap-around@ and coordinated services for children and adolescents coping with serious emotional disorders.

3. Maine has completed the consensus process and has begun to implement the exemplary practice of family psychoeducation.

Measure 1: 50% of Phase I grantees achieve consensus on, and move toward adoption of an exemplary practice within their community=s system of care. 50% of grantees have appropriate process data to enable them to move to Phase II.

Rationale: Phase I grants are for a maximum of one year. The goal of these grants is to reach consensus or agreement among all key stakeholders that the exemplary practice can and should be implemented. Consensus must be in sufficient detail that it resolves all critical issues and represents a commitment to adopt the practice within a certain timetable. Since this is a new program, targets will be revised when the first round of grants is completed and baseline percentages are established.

FY 1998 Projected Baseline: 40% reach consensus and move toward adoption.
FY 2000 Target: Increase to 50%
Data Source/Validity of Data: Program records of grant reports will include consensus information and actions taken.

Measure 2: 50% of exemplary practices funded in Phase I grants are adopted in Phase II.

Rationale: The first Phase II grants are planned to be awarded in FY 1999. Successful grantees will have up to two years to fully adopt an exemplary practice that has been agreed upon by the stakeholders. Since these grants will not be awarded until FY 1999, all targets will be revised when the first round of grants is completed and the baseline percentages are established.

FY 1999 Baseline: To be determined.
FY 2000 Target: To be determined

Data Source/Validity: Program records will include consensus information and actions taken.

Goal 4: Enhancing service system performance

No programs highlighted prior to FY 2000.

Center for Substance Abuse Prevention

Note: The table which follows lists all significant Center for Substance Abuse Prevention (CSAP) programs. Many programs, especially Knowledge Development and Knowledge Application programs, are time-limited. Some are ongoing. The table identifies the fiscal year (FY) each program began and the FY the program will be completed. Time-limited programs generally are first reported in the GPRA plan section of the Budget Submission once baselines have been determined, targets set, and update data are being collected. Final reporting of these programs generally occurs one to two years following completion of the program.

Summary information on how proposed or newly initiated programs are to be measured may be found in the budget narrative section of the Budget Submission.

Programs	**First Funded**	**Completed**	**First Reported**
Current			
Goal 1: Prevention Intervention Studies on Predictor Variable by Developmental Stages	FY 1996	ongoing	FY 1999
Goal 1: Starting Early/ Starting Smart: Early Childhood Collaboration Project	FY 1997	ongoing	FY 2000
Goal 1: Workplace Managed Care	FY 1997	ongoing	FY 2000
Goal 1: Youth Connect-High Risk Youth Mentoring/ Advocacy Program	FY 1998	ongoing	FY 2001
Goal 1: Initiatives on Welfare Reform and Substance Abuse Prevention for Parenting (Short title: Parenting Adolescents)	FY 1998	ongoing	FY 2001
Goal 1: Children of Substance Abusing Parents (COSAP)	FY 1998	ongoing	FY 2001
Goal 2: CSAP Clearinghouse program	FY 1997	ongoing	FY 2000
Goal 2: Centers for the Application of Prevention Technologies (CAPT)	FY 1997	ongoing	FY 2000
Goal 2: National Public Education Efforts (linked to YSAPI)	FY 1997	ongoing	FY 2000
Goal 3: CSAP Community Coalitions Program	FY 1997	FY 1999	FY 1999
Goal 3: State Incentive Grants (component of YSAPI)	FY 1997	ongoing	FY 2000
Goal 3: CSAP 20% Percent SAPT Block Grant Prevention Set-Aside	FY 1997	ongoing	FY 2000
Expected			
Goal 1: Vulnerable Populations	FY 1999	FY 2002	FY 2003
Goal 1: Family Strengthening	FY 1999	FY 2002	FY 2003

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Goal 3: Assure services availability/meet targeted needs

a. CSAP 20% SAPT Block Grant Prevention Set-Aside

Goal: To assist States and communities to expand and enhance the availability, delivery, and quality of substance abuse prevention services nationally, while enhancing State flexibility to target funds to local substance abuse priorities by a) improving, monitoring, and complying with Block Grant requirements, and b) testing outcome measures associated with reducing alcohol and drug abuse.

Measures: Standard measures will be applied to this activity where possible. It is important to recognize that there are few prevention requirements imposed by the SAPT block grant legislation and therefore CSAP has little direct control over the intermediate and long term outcomes. As States move toward consensus regarding common use and reporting of outcome data, CSAP will transition toward performance measures that will reflect those agreements.

Program update/performance report: States vary widely in the extensiveness and scope of their prevention services. While some depend entirely on the 20% set-aside for supporting their prevention programs and activities, others use these funds to fill major gaps in their programs and enrich others for greater impact. CSAP continues to use the funds allocated to it under the set-aside for providing States useful support services for making optimal use of the set-aside funds under the Substance Abuse Prevention and Treatment Block Grant as well as their State and foundation funds dedicated to prevention activities. One of the most significant impacts of CSAP's efforts is to generate synergistic effects of bringing States together around common problems with solutions specific to their own special conditions. Another special feature of this approach is to raise the level of functioning and effectiveness of States which are less advanced than others.

Measure 1: Increase the percentage of States that will incorporate needs/ resource assessment data into intended use plan in the block grant application

Rationale: Scientific findings from State needs assessment studies must be operationalized into resource allocation and strategy selection choices. This is not only important from the point of accountability but is an indicator of continuing quality improvement in services and their impacts.

Data source: Block Grant application.
FY 1998 baseline: To be available in FY 1999.

Program update: As the number of States with adequate funds for needs assessment and data infrastructure (see FY 2000 initiative) increases, their ability to incorporate those data into their block grant applications will increase correspondingly.

Measure 2: Increase the percentage of States that will apply block grant funds to activities in each of the six prevention strategy areas.

Rationale: Substance abuse prevention research literature strongly suggests that just as there is multifactorial causation of substance abuse, in order to be effective, prevention activities have to be multifaceted, repetitive and increasing in dosage. Thus, State programs with block grant-funded interventions distributed in each of the legislatively indicated six strategy areas are more likely to achieve a comprehensive prevention program and are motivated to work in that direction.

Data source: Block grant application.
FY 1998 baseline: To be available in FY 1999.

Progress update: CSAP has been working closely with the States in helping them meet this block grant requirement.

Measure 3: 90% of states will provide a satisfactory rating of TA services received within prior two years.

Rationale: Technical assistance that is appropriately designed, marketed, and targeted will meet State needs and will serve to enhance local prevention efforts. To varying degrees, States need assistance in putting to effective use available science-based reports, studies, and analyses. Most of such literature is written by researchers for researchers and exists in locations/sources that are unfamiliar or not easily accessible. There is a great need for such materials to translated and transformed into educational materials which are user-friendly and disseminate them effectively.

Program update: The technical assistance structure is being examined for improvements which will enable CSAP to meet the above target.

Data source: Customer satisfaction survey
FY 1997 baseline: 90%, with 60% responding.

Measure 4: Identify 5 potential prevention performance outcome measures through the minimum data set activity, and complete testing in at least 11 States (FY 1999 target).

Rationale: The identification of performance measures for mental health and substance abuse has been identified as a critical need. These measures will ultimately become SAMHSA=s block grant-related performance measures. The measures will not change from FY 1999 because the subsequent activities will be focused on evaluating and modifying the pilot system and deploying it nationally.

Program update/performance report: A minimum data set (MDS) initiative is underway to assist Sates and CSAP in the development, implementation, and application of a State uniform performance monitoring and measurement system. Eleven States participated in the Phase I pilot of the program, which focuses on process measures and services data. A collaborative effort resulted in agreement on data items, definitions, methods of data collection, the development of a PC based software system, and technical assistance related to training and installation. At last report, data were currently being collected at the program level and aggregated at the sub-State and State levels by seven States, seven more States were in the process of implementing the system either by pilot testing the system with a subset of their providers or going directly Statewide, and twenty-three additional States had requested technical assistance in the form of briefings and/or training in order to evaluate the system. Once sufficient data have been collected, participating States can use the results to allocate resources and improve State planning for prevention programs. Phase I data will be provided to CSAP for analysis and aggregation at the national level, which will provide important information about the number and types of prevention services provided and populations served..

Phase II focuses on intermediate and long term outcome measures and is expected to be completed in 1999. These measures will be field tested in the SIG States as part of their broader core measures for their feasibility for use in future block grant reporting. At the same time as planning and design of Phase II progresses, a considerably more advanced Phase I software system is being planned. This would significantly reduce the cost and time of developing an entirely new product and yet provide States and CSAP data and functions that would not otherwise be available for several years. Several States are currently developing technology that if integrated or linked could create a comprehensive and powerful State and national prevention expert system from needs assessment to performance measurement. These technologies are being considered and discussed in relation to CSAP=s core measures initiative and their future promise in helping the field improve their accountability systems.

FY 1997 baseline: 0 performance measures were tested.
Data source/validity of data: States= information systems and surveys of states. Reliability and validity will be assessed in the feasibility phase.

Program update: We expect to achieve this target in FY 2000. Indicators have been incorporated in the core measures that are being used by the State Incentive grantees.

b. State Incentive Grants (a component of YSAPI)

Goal: The State Incentive Grant (SIG) program of the Center for Substance Abuse Prevention (CSAP) has a twofold purpose and related goals:

- Governors should coordinate, leverage and/or redirect, as appropriate and legally permissible, all substance abuse prevention resources (funding streams and programs) within the state that are directed at communities, families, youth, schools and workplaces in order to fill gaps with effective and promising prevention approaches targeted to marijuana and other drug use by youth.

- States should develop a revitalized, comprehensive statewide strategy aimed at reducing drug use by youth through the implementation of promising community-based prevention efforts derived from sound scientific research findings.

Program update/performance report: States have agreed on the use of core data to be collected across sites at the State, subrecipient and program levels. States are also reaching agreement on the instrumentation that will be used to collect those data (both process and outcome.) From these core measures, SIG States will also field test several for their feasibility and usefulness in Block Grant application reporting. The SIG evaluation framework articulates the program theory or logic model upon which the SIG program will develop its structural elements and deploy its general intervention strategies. The framework represents assumptions and causal expectations about how SIG program activities align to produce the desired outcome of a revitalized, coordinated and comprehensive prevention infrastructure within a State: (1) SIG mobilization; (2) State-level system characteristics/dynamics; (3) sub-recipient characteristics/dynamics; (4) State-level collaborative strategies/activities; (5) sub-recipient planning/science-based prevention interventions; (6) State-level immediate outcomes; (7) sub-recipient immediate local outcomes; (8) State-level systems change; (9) intermediate outcomes (risk and protective factors); (10) long-term outcomes (behavioral impacts); (11) contextual conditions (economic, cultural). For example:

Long-term outcomes: Substance use

Constructs	Indicators	Data sources	Instruments/measures
Alcohol use	Lifetime, annual, monthly use; age of first use	Youth survey	Seven-state consortium survey item Youth risk behavior survey item Household survey
	Binge drinking	Youth survey	Seven state consortium survey item Youth risk behavior survey
Tobacco use (cigarettes)	Lifetime, annual, monthly use; age of first use	Youth survey	Seven state consortium survey item Youth risk behavior survey Household survey
Marijuana use	Lifetime, annual, monthly use; age of first use	Youth survey	Seven state consortium survey Youth risk behavior survey Household survey
Other illicit drugs	Lifetime, annual, monthly use; age of first use	Youth survey	Seven-state consortium survey Youth risk behavior survey

Constructs	Indicators	Data sources	Instruments/measures
			Household survey

The bottom line impact of interest for the SIG projects is the reduction of alcohol, tobacco and illicit drug use in the target populations of the local sub-recipient communities. Many of the individual SIG grantees have other long-term, health-related outcomes of interest: reductions in juvenile delinquency, teen pregnancy, violent behavior, etc. across the five grantees, however, there were several outcomes in common: alcohol use; tobacco (smoking) use; marijuana use; and other illicit drug use. In general, measures of actual use of each of the substances listed above included four primary indicators: lifetime use, annual use, 30-day use, and age of first use. Finally, the importance of evaluation in this far-reaching CSAP initiative has been abundantly emphasized at all levels. SIG grantees have responded to this with their own detailed plans and willingness to compromise on behalf of the national agenda.

Measure 1: Increase State level collaboration rating from the 1998 baseline

Rationale: The States receiving SIGs are developing new substance abuse prevention systems through collaboration with other State agencies and the combining and leveraging of resources and dollars. Over the 3 years of funding, each State will document and evaluate this new prevention system and do qualitative comparisons with the Aold@ prevention system. Collaboration will be rated using a survey being developed jointly by the initial cohort of SIG grantee states. Data will be aggregated by CSAP through a central data coordinating system and cross site comparisons will be conducted.

FY 1998 baseline: SIG States have completed their instrument development and will be collecting the data over the next months. Cross-site analysis will determine the average level of collaboration across the program. Baseline data to be available in FY 1999.
FY 2000 Target: To be determined when baseline data are available.

Data source/validity of data: States have agreed on the use of the same instruments and types of data to be collected. Data will be collected through several mechanisms: State grantees, subrecipients (local community or provider project level) and through school and community-based surveys. Data will be sent to a CSAP data retrieval system for entry and documentation.

Progress update: The first cohort of States has identified the factors that contribute to state level collaboration and developed a draft survey that will be administered to state agency representatives. SIG grantees will employ a standard approach to identifying the top five State agencies in their State and will use a common State agency collaboration interview to measure the frequency and extent of collaboration among these five top State agencies.

Measure 2: In FY 2000, past month substance use will decrease by 15% among youth ages 12 -17 from the baseline (YSAPI measure)

Rationale: States will be measuring the reduction in youth substance abuse via State level measures, community level measures, and specific program measures to determine the effectiveness of science based prevention programs and the effectiveness of the new prevention system. The decrease in risk indicators will also be examined. These and other data will be aggregated by CSAP through a central data coordinating system and cross site comparisons will be conducted.

FY 1998 baseline: To be available in FY 1999.
Data source/validity of data: The NHSDA, a national survey with known and established reliability and validity, will be used, as well as individual State school surveys. Program data are not yet available.

Progress update: States have agreed to include the same items to measure this variable across State sites at all levels of analysis (State, community, program). This is a major forward step in moving towards State core performance measures.

While the NHSDA can provide indirect State estimates (in most cases); the State surveys will be especially helpful by allowing analysis at lower levels (regional, local, program).

c. CSAP Community Coalitions Program

Goal: To increase community involvement in dealing with problems of substance abuse and its attendant effects; to promote the development of infrastructure in communities for initiating and facilitating substance abuse prevention activities.

Measures: This program has been completed, so existing measures will be utilized to report results.

Program update/performance report: Final analysis of the data collected as part of the national evaluation of the community partnership program is complete and efforts to disseminate the findings from the evaluation continue. Residential and school surveys, over two points in time, showed that 24 representative partnership communities as a group were associated with lower rates of substance abuse, relative to 24 matched comparison communities as a group. Of the 12 measured outcomes (covering alcohol or illicit drug use for each of the three age groups -- adults, 10th graders, and 8th graders, in the past month and the past year), only adults= alcohol use for the past month was statistically significant. For the partnership communities, male substance abuse rates were lower at the second point in time, relative to the comparison communities - usually by about three percent - on five out of the six outcomes: adult illicit drug use and alcohol use in the past month; 10th grade illicit drug use in the past month; and 8th grade illicit drug use and alcohol use in the past month (all comparisons were statistically significant. In contrast, female substance abuse rates were significantly different for only one of the six outcomes, and the partnership communities= rates were higher for 8th grade illicit drug use in the past month. When the responses for males and females were combined, only one of the six outcomes was significantly different, and favored the partnerships.

When comparing individual partnerships with their paired comparison communities, 8 out of 24 partnerships showed statistically significant reductions in substance abuse. The surveys also revealed other statistically significant findings associating partnerships with the following outcomes:
Adults who report less illicit drug use also reported being in a partnership community (not comparison community); being more involved in prevention activities; living in a Agood@ neighborhood (i.e., - a neighborhood free from drugs); and having a disapproving attitude toward drugs. The study showed that gaining community involvement and recruiting and involving members in all aspects of community infrastructure building and prevention program implementation were significantly related to attaining the partnerships= stated prevention goals. The study also identified several characteristics that were exhibited by those partnerships that had statistically significant reductions in substance abuse: a comprehensive vision that covers all segments of the community and all aspects of community life; widely shared vision that reflects the consensus of diverse groups and citizens throughout the community; a strong core of committed partners at the outset of the partnership; an inclusive and broad-based membership with participation of groups from all parts of the community; avoidance or resolution of severe conflict that might reflect misunderstanding about a partnership=s basic purpose; decentralized units within a partnership that encourage implementing prevention programs in small areas within a partnership and that empower residents to take action and make decisions; low staff turnover that, when it happens, is not disruptive; and extensive prevention activities and support for local prevention policies, reaching a large number of people for an extended period of time.

The Coalition program evaluation is using a time series design of archival data indicators. Complete data are expected for next year=s report. Preliminary results of analyzing trends in the health and the fatal accident indicators between 1992 and 1996 show no substantial differences between the coalitions and their matched comparison sites during the early implementation period of the community coalitions program. This is not surprising, given the conceptual framework model, which posits that a series of steps must occur between program implementation and the realization of the long-term program goals of reducing substance abuse and its related consequences. It was also observed that formally organized coalitions claimed more prevention outcomes than informally organized coalitions. Future plans include relating these coalition characteristics with the results of the analyses of the archival data.

Measure 1: Increase the mean number of organizations participating in coalition activities by 40%.

Rationale: Infrastructure development institutionalizes knowledge intended to be practiced through the community coalitions program, increasing the probability that its positive effects will last after the coalition is formed and its prevention programs are initiated. CSAP- supported community coalitions are required to have a minimum of two partnerships, and state-coordinated coalitions are required to have a minimum of three partnerships. A partnership is defined as a formally structured group of no fewer than seven (7) official member entities. During the first year of funding **C** FY 1995 **C** the number of partners in each coalition ranged from 2 to more than 50, with a mean of 6.3 partnerships in each coalition. As coalitions develop over the course of the grant period, both the number of community organizations and the number of partnerships participating in coalition activities is expected to increase.

FY 1995 baseline: mean of 46 organizations participating in coalition activities.
Data source: CMIF

Program update: The preliminary analysis of the process variables indicate that the coalitions have been involving an increasing number of organizations in the coalitions and have been increasing the extent to which they have adopted formal procedures such as having an governing board with elected officers and having formal operating procedures. For example, the mean number of organizations participating in coalition activities has increased from the baseline (measure 1) of 46 in 1995, to 172 in 1997; an increase far exceeding the target of 40%. Preliminary data analysis indicates that in 1998, the mean number of organizations participating in coalitions has increased even more to 186.

Measure 2: Increase prevention services that promote the coalition=s substance abuse prevention efforts by 100% from the base year.

Rationale: In 1995, the coalitions were starting and getting organized. Over the course of the grant period, the coalitions will complete assessments to identify needed prevention services, develop plans to meet those needs, and implement the plans. This is likely leads to an increase in substance abuse prevention services. Rates are not expected to increase during the last years of the funding period due to increased attention on evaluation activities during that period.

FY 1995 baseline: 595 prevention programs and services coordinated and implemented by 123 community coalitions.
Data source: CMIF. Information is verified via site visits, monitoring activities, and other reports.

Program update: The coalitions have surpassed all expectations for measure 2. For example, FY 1997 data show that 1803 prevention programs and services were facilitated and newly created; an increase of approximately 300% (rather than the 100% targeted). Preliminary analysis of 1998 data indicate that 2297 programs and services have been facilitated and/or created thus showing similar progress.

d. Synar Amendment (Section 1926) Implementation activities

Program goal: To reduce the sales rate of tobacco products to minors in all States.

Measures: This program will be examined for the feasibility of transition to new measures; in addition, the measures shown will be used.

Program update: All states have enacted such legislation. States are working (with supportive technical assistance) to establish and improve their data collection and enforcement procedures to comply with Synar regulations. Coordination with CDC and FDA continues.

Measure 1: In FY 2000, eight additional States (4 more than the 1999 target) will reduce their tobacco violation sales rates to minors to a maximum of 20%, making a total of twelve states at or below 20%. (FY 1999 target: increase to a total of eight States)

Rationale: Research evidence indicates that only consistent and vigorous enforcement of Sate tobacco access laws will reduce the sales of tobacco products to minors to 20% or less, and that through rigorous enforcement, all States can achieve that goal by September 30, 2003.

Baseline: The FY 1997 baseline for States with violation rates at or below 20 percent was four.

Data source/validity of data: The data source is the Synar report which is a part of the SAPT block grant application submitted annually by each State. The validity and reliability of the data are expected to be high in view of the TA being provided, the number of random unannounced surveys being conducted, and the confirmation of the data by scientific experts, site visits and other similar steps.

Measure 2: Maintain at 100% the proportion of States provided with periodic technical assistance in implementation of guidelines to meet Synar goals.

Rationale: CSAP is in a unique position to provide leadership and guidance to States on overcoming barriers to developing appropriate sample designs and other technical materials, based on scientific literature and demonstrated best practices, for the effective implementation of Synar. The FY 1999 measure of 100% will be maintained.
FY 1998 baseline: In FY 1997, twelve States received technical assistance in implementing the guidelines to meet the Synar goals.

Data source/validity of data: The data sources for the baseline and measures were derived from State project officers' logs and organizations who were awarded State TA contracts. The analysis will be based upon the actual requests/responses received, thereby providing a high degree of reliability and validity.

Goal 1: Bridge the gap between knowledge and practice

a. CSAP Prevention Intervention Studies on Predictor Variables by Developmental Stages

Goal: To generate new empirical knowledge about effective approaches for changing the developmental trajectory of children at risk of substance abuse.

Program update/performance report: Interventions are proceeding as planned. The results of this cross-site analysis are expected in October 1998. The Predictor Variables Program is in its second year. The following site example demonstrates the type of quantitative results anticipated once the program analyses are completed:

Phase I (summer, 1997): Program design used a 7-week highly intensive and focused behavioral interventions, a social skills training component in natural settings with peer group and dyadic experiences, and structured opportunities for sports/hobbies skills training and recreational activities designed to create an overall positive experience for the child.

	Exp		Control		Manova f	
Hyperactivity	mean	sd	mean	sd	time	t x group
pre	2.51	.78	2.33	.63		
post	2.25	.76	2.30	.70	6.8*	4.3*

*p< .05, **p < .01, ***p <.001

Aggressive/ Disruptive	Exp mean	sd	Control mean	sd	Manova f time	t x group
pre	1.72	.32	1.68	.42		
post	1.55	.32	1.60	.34	33.7***	4.4*

*p< .05, **p < .01, ***p <.001

Concentration Problems	Exp mean	sd	Control mean	sd	Manova f time	t x group
Pre	2.27	.43	2.22	.49		
Post	2.00	.41	2.12	.44	34.7***	7.4**

*p< .05, **p < .01, ***p <.001

Higher scores indicate greater severity of problem

In addition, the experimental group showed significant improvements on measures of social adjustment, including task orientation, frustration tolerance, assertive skills and peer social skills. Also noteworthy were school attendance rates that exceeded 90% throughout the summer program and high rates of parent participation at scheduled parent night activities [n=240 (100%) at the final parent night]. Approximately 95% of the parents expressed desire to continue with the early risers program.

Implication: children with early-starting aggressive and disruptive behavior are at heightened risk for the development of alcohol and drug abuse. As a consequence of their aggressive behavior they underachieve in schoolwork, are rejected by their peers, enter into coercive interactions with their parents and siblings, and develop low self esteem. Improvement in self regulation of behavior is considered essential first step to the prevention of later substance abuse.

Measure 1: 80% of sites (8) will implement effective intervention models for all populations designed to be disseminated through professional journals and meetings in the field of prevention (FY 1999 target; end of grant period).

Rationale: Aside from generating findings on the effectiveness of the interventions and determining the impact of each of the four predictor variables on children and parents, this program expects to generate intervention models that can be disseminated to state and local communities interested in implementing age appropriate substance abuse prevention programs. These programs are for all populations including those children at risk for substance abuse that have been identified by previous demonstration grant programs, (e.g., the child development project (grant # 1H86SPO2647) a five-year initiative, 1991). These studies will end unless funds are made available for further competitive funding to continue them as longitudinal studies.

FY 1998 baseline: 0 sites (10 grant sites received initial awards in 1997).

Progress update: All sites have collected and submitted baseline data to the research coordinating center for analyses. Several of the programs have collected intervention data and are starting to generate preliminary findings. Following are examples of promising significant findings submitted by individual sites:

- Preliminary analyses indicate significant improvements in children=s aggressive behavior placing them at less risk for future substance use.

- Preliminary findings that showed significant improvement when compared to the control groups were made in the areas of: improved parenting behaviors (parenting ability, utilization of discipline techniques), increased family cohesion, increased family organization and decreased family conflict. Furthermore in relationship to children=s behavior, statistically significant improvements, when compared to the control groups, were made in

improved self control, improved cooperation, improved social competencies (as measured by the early elementary behavior rating scale) and decreased conduct problems.

Based on the above preliminary findings, we anticipate that we will be able to meet our target for Measure 1.

Data source: final reports

Measure 2: Children 9 years of age and over in the treatment groups will show percentage decreases in alcohol, tobacco, and drug use when compared to children in the comparison group (FY 1999 target; end of grant period).

Rationale: Intervention research has provided indications that it may be possible to change disordered behavioral patterns of young children if interventions begin early and are targeted at several predictor variables including social competence, self regulation, school bonding and academic achievement and caregiver investment. As previously described, research studies have found these indicators to be highly predictive of use. It is anticipated that this initiative will be successful in changing this developmental path toward deviant behavior and lead to more healthy social and emotional development as well as reduce the incidence of substance abuse disorders.

FY 1999 target: to be established by mid-FY 1999.

Baseline:

	9-11 AGE COHORT	12-14 AGE COHORT
TOBACCO USE	2.5%	7.5%
ALCOHOL USE	4.5%	8.3%
MARIJUANA USE	.8%	2.3%
TOTAL USE	7%	13.3%

Data source: Sites in this program must use standardized and validated instruments. Results must be reported in the final report. Accuracy of results can be verified from re-examination of raw data and quality control procedures.

Progress update: Based on the preliminary data described above, and the proven association of these factors with substance use, we anticipate results of the final cross-site analysis to yield findings that demonstrate success in achieving our target for Measure 2.

b. Starting Early/Starting Smart: Early Childhood Collaboration Project

Goal: To test the effectiveness of integrating mental health and substance abuse prevention and treatment services (behavioral health services), for children ages birth to seven years and their families/care givers, with primary health care service settings or early childhood service settings.

Measures: Performance measures have been revised to remove unnecessary process measures and to reflect the types of data that will be received, and the baseline data which have been received. This FY 1997 program will be examined for feasibility of transition to new measures; meanwhile, the revised program-specific measures shown below will be applied. Core measures include extent and normative comparisons of key measures in each of 4 areas. Some examples include :

I. Parental functioning: Parental substance abuse; Parental mental health status
II. Child functioning: Health status; Language development; School readiness; Social functioning; Behavior

III. Parent-child dyad: Parental discipline; Bonding
IV. Service integration: Inter/intra-staff contacts; Appropriate service utilization

Program update/performance report: Because the dollars are awarded as cooperative agreements, an invigorated partnership has been developing, now involving 12 community grantees, and a data coordinating center. Throughout the first nine months of this project (Phase I) they have been working collaboratively to design the cross-site research design, using core measures across sites, which can best develop critical new knowledge for the early intervention field.

Measure 1: SAMHSA and 100% of the federal and private partners to this effort will have executed memoranda of understanding (MOU) that specify their mutual expectations (FY 1999 target).

Rationale: One of the goals of SESS is to foster public/private collaborations to create a more comprehensive framework for improving services to young children and their families. Collaborations across government agencies and private sector organizations promote systems integration and streamline the process for providing services.

FY 1997 baseline: 50 percent of the collaborators have MOUs.
Data source/validity of data: CSAP records substantiating the execution of these official agreements. This measure will be dropped once its target is achieved.

Progress update: Due to the collaborative environment described above, we expect to achieve our target of 100% execution of our MOUs with our federal and private partners.

Measure 2: Establish baseline data on physical health, behavior, social and emotional functioning and language development of participating children ages 0 - 5 by compilation and analysis of collected data from the initial administration of the determined protocol instruments (FY 1999 target; measure will be revised to set FY 2000 targets once baseline data are collected).

FY 1997 baseline: Baseline data to be available in FY 1999.
Data source/validity of data: Multiple selected, sometimes modified, standardized instruments, agreed upon by consensus of the steering committee, are used.

Progress update: As previously described, the collaborative environmental context of the SESS project has enabled its partners to agree in FY 1998 on the core measures and instruments to be used across sites. Therefore, we do not anticipate a problem in achieving our goal of establishing baseline data on those measures.

c. Youth Connect - High Risk Youth Mentoring/Advocacy Program

NOTE: This Knowledge Development program is supported by the High Risk Youth budget activity.

Goal: Youth Connect is a knowledge development (KD) program that seeks to prevent or reduce substance abuse or delay its onset in youth, 9-15 years of age by improving 1) school bonding and academic performance, 2) family bonding and functioning and, 3) life management skills.

Measures: Standard measures will be identified and applied to this activity following award. In addition, the program-specific measures listed below will be applied. The outcomes associated with Across Ages for study participants relative to no-treatment controls include:

- mentored youth (mps) and the limited treatment group (ps) had fewer days absent
- mps youth demonstrated improvement in their attitudes towards the future, school and elders.
- mps youth demonstrated large gains in their knowledge/ perceived ability to respond appropriately to situations involving drug use.

- C mps youth gained more knowledge than ps and comparison youth of community issues.
- C mps youth with exceptionally involved mentors (higher dosage), in comparison to those with average or marginally involved mentors, gained knowledge about the potential risks and consequences of substance use, increased perceived ability to respond appropriately to situations involving drug use, and reduced school absenteeism.

Based on findings from previous CSAP activities (see example above), CSAP will evaluate the effectiveness of mentoring interventions with diverse programs that employ professional and paid mentor/advocates, who will be required to spend an extensive and specific amount of time with their mentees and/or their families/caregivers. CSAP wants to determine the effectiveness of mentor/advocates with youth-alone versus youth with their families. It is anticipated that this intervention will be effective in reducing substance abuse and related violence, as well as improving community attitudes about youth and enhancing the system of support available to them and their families. Mentoring programs are of interest to ONDCP and individual States as well as CSAP

Program update/performance report: Awards were made in FY 1998 to 15 study sites and a coordinating center that is charged with the responsibility of working with these grantees to determine core data sets, coordinating an evaluation across sites, and ensuring the integrity of the data.

Measure 1: A decrease of 10% in the rates of substance abuse and related violence for treatment subjects relative to similar populations not receiving comparable prevention programming (FY 2000 target).

Rationale: Prior research has demonstrated that improving school bonding and academic performance, improving family bonding and functioning, and improving individual life skills can serve as protective factors to prevent youths' abuse of substances. This initiative targets collection of individual data for treatment and comparison groups to determine the success of the interventions in positively affecting these areas.

Baseline: All funded project sites submit baseline and annually collected data to the data coordinating center which, in turn, analyzes and submits the cross-site data to CSAP; all baseline data are anticipated to be generated in FY 1999 and available in FY 2000.

Data source: Data will be collected on sociodemographic characteristics, children's interactions with their parents/caregivers and other family members as well as school and community. The steering committee will begin a selection of a core set of instruments to be used across sites. It is anticipated that measures will be collected on how the prevention intervention and associated services can be effective in preventing, delaying and/or reducing his/her substance abuse, improving school bonding and academic performance, improving family bonding and family relationships and improving life management skills. Implementation or proximal measures of outcomes should include frequency, level of subject participation etc.

Measure 2: 60% of sites will be able to document models that are determined to be both effective and replicable (FY 2000 target).

Rationale: in addition to providing findings on effectiveness, it is expected that these studies will produce replicable models that can be disseminated to state and local communities interested in implementing effective mentoring/advocacy programs.

Baseline: Baseline data to be available in FY 1999.

Data source: All instruments will be reviewed and chosen at the first steering committee meeting.. Models will be fully documented with both qualitative and quantitative data and will include face-to-face interviews, surveys, paper and pencil written questionnaires, psychological testing, administrative records and participant observation.

d. Cooperative Agreements for Public/private Sector Workplace Models and Strategies for the Incorporation of Substance Abuse Prevention and Early Intervention Initiatives into Managed Care (short title: Workplace Managed Care)

Goal: The overall goal of this cooperative agreement program is to determine which public/private sector workplace managed care substance abuse prevention and early intervention programs are the most effective in reducing the incidence and prevalence of substance abuse and to disseminate these findings. Objectives are: (1) to determine the nature (e.g. structure, organization, function, etc.) of workplace managed care (WMC) programs utilizing substance abuse prevention and early intervention efforts; and (2) to provide a detailed description of the WMC programs; assess their strengths and weaknesses and their impact on the substance abuse of employees and their families (e.g. covered lives); and assess the quality and delivery of substance abuse prevention and early intervention.

Measures: This program will be examined for feasibility of transition to new measures in addition to the measures presented below.

Baselines and targets: To be determined by the end of FY 1998.

Data sources: Employer and health care organization records; cross-site program survey to be developed.

Program update/performance report: A steering committee, composed of grantees, the coordinating center and CSAP has developed research questions and core measures for answering them.

Measure 1: CSAP and the 9 funded cooperative agreements will agree to core process and outcome measures for the cross-site analysis (FY 1999 target).

Rationale: One of the goals of the WMC program is to complete a cross-site analysis of the funded cooperative agreements and to be able to study findings across the sites.

FY 1998 baseline: No consensus at program start across sites.

Data source: CSAP records, grant reports, WMC cross-site database

Progress update: CSAP and the nine funded cooperative agreements have agreed on core outcome measures for the cross-site analysis. Consensus is expected in early 1999 regarding the core process measures. By December, 1998, retrospective data have been provided by two grantees and baseline data were provided by eight grantees. Retrospective data should include: human resource, employee assistance program (EAP)/family and employee assistance program(FEAP), and claims data.

During Phase I of the study the nine study site evaluation teams focused their efforts in gaining full understanding and knowledge of their collaborating worksites and the prevention/early intervention strategies implemented within these worksites. . To date, all nine grantees have submitted their logic models to the coordinating center for review. Phase II of the study has focused on developing the WMC core data set. At present, the steering committee has reached a consensus on the common elements of the core data set to answer many of the programs main outcome questions. The core data set includes records based data from the worksite, EAP, MCO, and other participating entities. For a subset of the participating study sites, workplace employee surveys will also be administered to collect data to be analyzed as part of the cross-site initiative.

Measure 2: Health care utilization will increase as defined by pre-post intervention in prospective studies (FY 2000 target)

Rationale: Research indicates that there are a number of intervening and outcome variables obtainable through health claims data which are important in studying the success of substance abuse prevention and early intervention programs in workplace managed care settings. Intervening variables including data of birth, sex, marital status are important to interpreting the data. Utilization and cost of emergency room services, utilization and cost of urgent/emergency room services; utilization and cost of outpatient services; utilization and cost of inpatient services; utilization and cost of substance abuse services and related medical conditions; utilization and cost of mental health services, have been shown to be good predictors of the success of the substance abuse prevention/early intervention programs. Health care utilization indicators include the relationship to subscriber, plan enrollment and disenrollment dates, location of service, cost of service, and ICD-0 diagnosis codes will be used across the nine sites. Financial outcome data have also been shown to be good predictors of the success of substance abuse prevention/early intervention programs however the exact measures have not yet been finalized.

Baseline and target: To be defined.

Data sources: Employer and health care organization records; program survey is being developed.

Progress update: Grantees are beginning to collect retrospective data and baseline data including: medical and mental health utilization and costs, drug testing data and costs, and human resource data from secondary sources. All nine funded grantees are currently preparing linkage files (human resources, employee assistance program, claims data, survey data) to send collected data for the cross site evaluation. Some preliminary evidence includes:

- G-4 has collected workers=s compensation claims, health care costs by 14 sites for 1996-1997 for more than 1,300 employees indicating combined number of claims of 287 with a range of 0 - 35.1% filing for the two years combined and healthcare costs of $708,053 for these claims. It built a retrospective database for 96 variables including drug testing and is completing its analysis.
- G-8 has completed creating its alcohol abuse prevention web site to assess employee=s risk for alcohol abuse/dependence which is designed as a prospective intervention; and analyzed retrospective health care utilization data. They found for 1997 there were 28,765 covered lives with a prevalence of .118% having substance abuse treatment needs. Preliminary analysis of OSHA 200 logs suggest 7.5% of the cases are alcohol-related.

The retrospective data will provide information and insight on the intervention strategies implemented at each worksite prior to the onset of the WMC study. The data collection schedule for the HR, MCO, EAP record-based data is expected once all test file procedures are complete and will continue on a quarterly basis. Test files are available for four grants; the remaining files should be available early Spring, 1999.

Goal 2: Promote the adoption of best practices

a. CSAP Clearinghouse Program

Goal: Increase substance abuse and mental health public information dissemination activities.

Measures: Standard measures will be applied to this activity. In addition, the measures from the FY 1999 GPRA performance plan, as modified below, will be applied during the transition to the new measures.

Program update/performance report: The new NCADI contract awarded on September 25, 1998, requires 10% of the budget to be used for evaluation. Questions include such topics as customer satisfaction and whether and how requestors have used the information received. NCADI is responding to the demand generated by the ONDCP National Youth Anti-Drug Media Campaign, which has stimulated twice the level of demand as compared to last year. Also, NCADI has moved into call center operations 24 hours a day, 7 days a week, to serve the ONDCP media campaign as well

as various CSAP public education campaigns (which have been adopted by the DHHS Secretary=s Office), and has taken on responsibility for CSAT=s National Treatment Helpline.

Measure 1: By FY 2000, increase the number of information requests received annually by 10% over the FY 1997 baseline (FY 1999 target: 5% over FY 1997 baseline).

Rationale: The distribution of SAMHSA/CSAP/CSAT, NIAAA, NIDA, Department of Education, Department of Labor, and other organizational print and audiovisual resources to the prevention, intervention, and treatment field is a standard measure for gauging the responsiveness to the public's need for information.

Items to be measured and reported include:

- the frequency of use of the following services of NCADI will increase by 5%: telephone; mail; PREVLINE website (www.health.org); staff, walk-in visitors;
- related to the ONDCP media campaign in 1998, where did the requestor get the 800 number? when did the requestor see/hear the advertisement? is the requestor getting materials to help talk with a child about substance abuse?

FY 1997 baseline: telephone: 13,750 requests per month; mail: 2,750 requests per month; Prevline: 1,100 requests per month; staff, walk-in visitors: 733 requests per month

Data source/validity of data: The NCADI contract has several tracking systems in place to account for the processing of phone calls, mail, e-mail, staff requests, and visitors. Each of these measures is reported to CSAP on a monthly basis and includes analyses of trends over time.

Program update: The current level of demand for NCADI services during a typical month is reflected in the following profile: 19,166 requests/month; 82 percent of inquiries are made by phone (523 calls/day); 8 percent by mail (51 orders daily); 8 percent by e-mail (51 electronic orders daily); and 2 percent by fax/in-person. The ONDCP National Youth Anti-drug Media Campaign, which was launched July 9, 1998, has had a significant impact on the number of calls to NCADI. After the first two weeks of the campaign, the NCADI contract experienced a 121 percent increase in caller volume as a result of the media advertising in 75 media markets. Historical records indicate that caller volume increases steadily each year regardless of whether broad-based media efforts are implemented. As of December 1998, ONDCP campaign=s media efforts has stimulated a doubling in demand for substance abuse information. Compared to the same timeframe in July last year, the increase in NCADI caller volume is 220 percent. This increased level of caller volume is expected to continue to escalate dramatically as the ONDCP media campaign expands its efforts.

Measure 2: In FY 2000, customer satisfaction will remain high (at least 85%). (FY 1999 target: customer satisfaction will remain high at 85%).

Rationale: This measure offers direct feedback on the experience of customers trying to access and use clearinghouse services and resources. New measures will be added as additional services are implemented.

Baseline: FY 1997 customer satisfaction rate of 85 percent. FY 1998 customer satisfaction rates have exceeded 90 percent.

Data source/validity of data: NCADI staff draws a random quality control sample from completed orders each month and customers are called on an ongoing basis during the following month. A customer service satisfaction report is generated every 6 months and submitted to CSAP. There are limitations to the data in that nonrespondents represent roughly 50% of the sample.

Program update: By FY 2000, it is expected that SAMHSA will have substantive qualitative and quantitative data on the NCADI contract=s performance in areas such as customer service (e.g., courteous and timely response to requests), marketing penetration of various products and services (e.g., audience impressions of radio and print public service

announcements), usage patterns of products and services (e.g., types of information being downloaded from PREVLINE), and utility of products and services (e.g., how was the information used and was it as intended). Currently, the NCADI contract has traditional tracking information (e.g., number of contacts, mode of contact, number of website hits, number of publications shipped, general customer satisfaction assessments). While helpful to describe levels of activity for the purpose of efficient resource allocation, the new NCADI contract is refining its evaluation efforts to use performance measures that more directly impact Federal program directions and activities.

b. National Public Education Efforts (linked to YSAPI)

Goal: To raise public awareness about substance abuse prevention issues, and to promote healthy changes in individual and group attitudes and behaviors.

Measures: Standard measures as well as the measures stated below will be used in this project.

Program update/performance report: There are currently three national media campaigns at various implementation phases: the Reality Check! Marijuana campaign, the Girl Power! Campaign and the Positive Activities campaign.

The **Reality Check** campaign is a multimedia campaign designed to prevent new use and reduce existing use of marijuana among 9- to 14-year olds. The *Keeping Youth Drug-Free (Guide for Parents, Grandparents, Elders, Mentors and Other Caregivers)* was the second most requested product in November 1998 at NCADI with 7,905 requests. Outreach numbers by print, television, radio and the website are listed below:

The **Girl Power!** campaign continues to build public-private partnerships at the national, state, and local levels to expand the reach of the campaign. For example, the Girl Scouts have developed a Girl Power! Girl Scouts merit badge. Working with CSAP, the Girl Scouts are developing the substance abuse prevention educational materials needed to earn this new badge. Also, grass-roots Girl Power! promotional events with celebrity spokespersons such as Dominique Dawes continue to flourish.

The **Your time -- their future** campaign, which emphasizes positive activities, targets parents and caregivers of youth ages 7-14 and is intended to encourage adults to become role models who can guide young people. CSAP launched the campaign in October 1998 with Secretary Shalala as the key spokesperson. Radio live scripts and English and Spanish video PSAs as well as supporting ancillary campaign materials are being distributed widely.

Measure 1: In FY 2000, there will be a 5% increase in media placements and media accesses to Prevline and the phone system over the FY 1997 baseline.

Rationale: Indicator for success of marketing efforts to achieve a high level of mass media penetration. This activity is used to establish and sustain relationships with a broad range of media. Placements and access can vary widely according to media coverage of substance abuse issues. Regular communications with the media results in a steady state of placements and access and a general awareness of SAMHSA/CSAP as a primary resource for information. When media interest in the issues is high, the number of media contacts rises dramatically. One evaluation limitation is that the number of placements and access does not provide information on how well the information was received by the intended target audience.

FY 1997 baseline: 5-15 percent response rate to media outreach efforts
Data source/validity of data: The NCADI contract has several tracking systems in place to capture these data and report them to CSAP on a monthly basis.

Program update: As a component of YSAPI and as a result of ONDCP's significant investment in media approaches to prevention, we do not anticipate a problem in achieving our measure 1 target.

Final budget appropriations may impact the achievement of identified objectives and targets.

c. Centers for the Application of Prevention Technologies (CAPT)

Goal: To increase the number of scientifically defensible programs, practices, and policies adapted and sustained by the state incentive grantees and their subrecipients.

Measures: This FY 1997 project will be examined for the feasibility of transition to new measures, in addition to the measures stated below. The evaluation results of the National CAPT program will indicate achievement of goals such as: increased accessibility to an application of proven substance abuse prevention strategies; expanded state and local capacity in the substance abuse prevention knowledge application process; increased access to and use of electronic methods in the region; and established regional capacity for ongoing mentoring and coaching. The National CAPT program also expects to learn about the Ascience and art of knowledge application.@ For example, which delivery methods are most effective in helping communities adopt and sustain the use of science-based prevention programs, practices, and policies? What configurations of skill development and capacity-building activities produced the greatest systems change?

Program update/performance report: The CAPT grantees are finalizing their process and outcome core measures. The CAPTS together have designed an instrument to be used across sites by their State and substate customers. CAPT grantees have attended several meetings including several with their associated SIG states. Baseline data should be available by the end of FY 1999 due to the lag time between CAPT awards and SIG grants and contracts to subrecipients who will be users of the CAPT services.

Measure 1: By FY 2000, there will be a 25% increase in the number of technical assistance contact hours and a 25% increase in the number of prevention technologies introduced to all SIGs and their subrecipients.

Rationale: States require sound technical support to ensure that their selection of prevention strategies, programs and policies (prevention technologies) are based on scientific evidence. These regional centers are designed to provide the necessary support in conjunction with CSAP, other HHS agencies such as NIDA and NIAAA, and other departments such as Justice and Education. The intent is to increase the number of proven prevention technologies adopted at the community level; assess how well the technology transfer activities were implemented; and provide ongoing technical assistance and capacity-building to these communities to ensure their successful adoption of prevention technologies.

Baseline for FY 1998: Being established as both the State Incentive program and the CAPT program start up.

Data source/validity of data: CAPT common data evaluation set will be based on an originally developed survey of CAPT users.

Program update: To ensure that the program needs of States and communities are met, the National CAPT program tailors its capacity-building services. From the individual level through comprehensive systemic change at the community/state/regional level, the National CAPT program is committed to working together with community and State organizations to design technical assistance and skill development services that will significantly enhance their respective prevention systems as well as the overall prevention infrastructure across the region. Because of the regional nature of the CAPTs organization, we expect that the close working relationships and responsiveness to our regional customers will result in the targeted increases described in measure 1.

Measure 2: By FY 2000, past month substance use will decrease by 15% from the baseline among youth ages 12-17 (YSAPI measure).

Rationale: Comprehensive public education efforts can effect a change in the perception of harm and associated drug use by youth 12-17 years old.

FY 1997 baseline: FY 1995 NHSDA rates and FY 1998 individual State rates for alcohol, illicit drugs and tobacco.

Data source/validity of data: NIDA Monitoring the Future National High School Survey and SAMHSA National Household Survey on Drug Abuse. These are national surveys with known and established reliability and validity.

Program update: To get research findings into practical use at the local level, SAMHSA/CSAP uses an integrated delivery approach (i.e., knowledge development**C**>knowledge synthesis **C**>knowledge dissemination**C**>knowledge application). Initially, new research information must be synthesized and repackaged for different types of users e.g., ranging from prevention professionals to community activists (e.g. SAMHSA/CSAP=s National Center for the Advancement of Prevention). Information is then disseminated through multiple communication channels e.g., print, radio, tv, Internet, exhibits, to introduce it into the prevention field (SAMHSA=s substance abuse and mental health clearinghouses, and media services). However, provision of information alone does not cause behavioral change. In order to effectively bring about changes which will significantly enhance the delivery of substance abuse prevention services at the local level, the National CAPT program=s knowledge application services (i.e., applying prevention that works) complete the cycle. The CAPTs program is one of the components of the integrated and simultaneously implemented YSAPI components that together will prove successful in achieving our target in measure 2.

Goal 4: No programs highlighted prior to FY 2000.

Center for Substance Abuse Treatment

Note: The table which follows lists all significant Center for Substance Abuse Treatment (CSAT) programs. Many programs, especially Knowledge Development and Knowledge Application programs, are time-limited. Some are ongoing. The table identifies the fiscal year (FY) each program began and the FY the program will be completed. Time-limited programs generally are first reported in the GPRA plan section of the Budget Submission once baselines have been determined, targets set, and update data are being collected. Final reporting of these programs generally occurs one to two years following completion of the program.

Summary information on how proposed or newly initiated programs are to be measured may be found in the budget narrative section of the Budget Submission.

	First Funded	First Completed	First Reported
Goal 1: Bridging the Gap			
Treating Adult Marijuana Users	FY 1996	FY 1999	FY 2001
Wraparound Services	FY 1996	FY 1999	FY 2001
Managed Care/Adults	FY 1996	FY 1999	FY 2001
Homelessness Prevention	FY 1996	FY 1999	FY 2001
Managed Care/Teens	FY 1997	FY 2000	FY 2002
Criminal Justice Diversion	FY 1997	FY 2000	FY 2002
Treating Teen Marijuana Users	FY 1997	FY 2000	FY 2002
Starting Early, Starting Smart	FY 1997	FY 2001	FY 2003
Exemplary Treatment Models	FY 1998	FY 2001	FY 2003
Women and Violence	FY 1998	FY 2003	FY 2005
Treating Methamphetamine Use	FY 1998	FY 2001	FY 2003
Treating Teen Alcohol Use	FY 1998	FY 2003	FY 2005
SA/MH in Aging Populations	FY 1998	FY 2001	FY 2003
Goal 2: Promoting the Adoption of Best Practices			
Product Develop. and Dissem.	FY 1999	ongoing	ongoing
Addiction Tech. Transfer Centers	FY 1998	ongoing	ongoing
National Leadership Institute	FY 1997	ongoing	ongoing
Community Action Grants	FY 1998	ongoing	ongoing
Goal 3: Assure Service Availability/Meet Identified Needs			
SA P&T Block Grant	ongoing	ongoing	ongoing
Targeted Capacity Expansion	FY 1998	ongoing	ongoing
Goal 4: Enhance System Performance			
State Treatment Needs Assessment	FY 1992	ongoing	ongoing
TOPPS	FY 1998	ongoing	ongoing

Goal 3: Assure services availability/Meet targeted needs

a. CSAT Substance Abuse Prevention and Treatment (SAPT) Block Grant

Goal: The legislative purpose of the SAPT Block Grant Program is to provide funding to States in support of treatment and prevention services for persons at risk of or abusing alcohol and other drugs. The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) is the cornerstone of the States: substance abuse programs, accounting for 40 percent of public funds expended for treatment and prevention (FY 1995). In 19 States (FY 1997), the grant provides the majority of funding available to support substance abuse treatment services. This vital program is indispensable to State efforts to maintain viable treatment capacities and to respond to the needs of those citizens who are greatest risk for alcohol and drug abuse.

CSAT is funding activities toward the development of outcome measures to assist the States in monitoring and evaluating substance abuse treatment services. In FY 1997, CSAT awarded 14 contracts to Single State Agencies under the Treatment Outcomes and Performance Pilot Studies (TOPPS) for the purposes of determining whether or not exportable models of outcome studies could be developed. In 1997 and 1998, the Office of the Administrator and CSAT convened meetings of States with NASADAD to identify promising outcome measures. The meeting produced the following preliminary list of common domains/indicators that are under review by the SSA's. This process is being coordinated with the TOPPS II initiative.

Domain I - Effectiveness

A. Indicator Areas -Health Status

Suggested bases for measurement

1. Physical Health
    a) Emergency Room visits
    b) Hospital admissions
    c) Hospitalization days
    d) Addictions Severity Index (ASI) health status (or equivalent)
    e) Medical outpatient visits
    f) Prenatal visits
2. Mental Health
    a) Emergency Room psychiatric visits
    b) ASI psychosocial health status or equivalent
    c) Outpatient psychiatric visits
    d) Psychiatric hospitalizations
    e) Psychiatric hospitalization days

B. Indicator Areas - Economic self-sufficiency

Suggested bases for measurement:

1. Legal income
2. Employment status
3. Use of public assistance
4. School: dropouts/suspension/grades(youth only)
5. Literacy (adults only)

C. Indicator Areas- Social Supports and Functioning Suggested

Suggested bases for measurement:

1. Living arrangements
2. Arrests/Juvenile justice
3. Self report crime-days
4. Incarceration

5. Legal status
6. ASI social support indicators
7. Child welfare

D. Indicator Areas - Substance Use
Suggested bases for measurement:
1. See Treatment Episode Data Set (TEDS)
2. See Methadone Treatment Quality Assurance System (MTQAS)
3. ASI AOD use or equivalent

Domain II - Efficiency
A. Indicator Areas - Access
Suggested bases for measurement:
1. Penetration
2. Utilization
3. Wait times

B. Indicator Areas - Retention
Suggested bases for measurement:
1. Completion rates
2. Length of stay (American Medical Association rates)
3. Rule violation/discharges

C. Indicator Areas - Costs of Services
Suggested bases for measurement:
1. Unit costs
2. Episode costs

D. Indicator Areas - Appropriateness
Suggested bases for measurement:
1. To be developed

Domain III - Structure
A. Indicator Areas - Service capacity/description
Suggested bases for measurement:
1. To be developed

B. Indicator Areas - Data capabilities
Suggested bases for measurements:
1. To be developed

C. Indicator Areas - Workforce competence
Suggested bases for measurements:
1. To be developed

D. Indicator Areas - Demographics
Suggested bases for measurements:
1. To be developed

E. Indicator Areas - Client Characteristics
Suggested bases for measurements:

1. To be developed

The awardees of TOPPS pilot projects are expected to cooperatively agree on a core set of performance and outcome measures, comparable across States, piloting those measures and beginning to collect performance and outcome data in those states. As indicated earlier, once this pilot work begins producing results, they will be highlighted in our GPRA reports. In addition, we will begin moving toward incorporating them into the standard block grant reporting forms.

Measures: Standard SAMHSA outcome measures will be applied to this program. Pilot baseline measures for outcomes will be available in FY 2000. Targets will be set at that time. In addition, several measures from the FY 1999 GPRA Performance Plan will be used during the transition to the new measures.

Measure 1: Overarching SAMHSA outcome indicators for adults and adolescents receiving substance abuse treatment will be reported voluntarily by those states who can as part of the FY 2000 block grant applications, as follows:

1) Over the past year, percent of adults receiving services increased who:
   a. were currently employed or engaged in productive activities
   b. had a permanent place to live in the community
   c. had no/reduced involvement with the criminal justice system
   d. experienced no/ reduced alcohol or illegal drug related health, behavior, or social consequences
   e. had no past month substance abuse

2) Over the past year, percent of children/adolescents under age 18 receiving services increased who:
   a. were attending school
   b. were residing in a stable living environment
   c. had no/reduced involvement in the juvenile justice system
   d. had no past month use of alcohol or illegal drugs (population data limited to 12-17 year olds)
   e. experienced no/reduced substance abuse related health, behavior, or social consequences

Rationale: On a voluntary basis information will be solicited in a nondirective format in the OMB approved Block Grant Application. Initial experience in FY 2000 will identify the need for additional improvements to data infrastructure.

Baseline: Baseline data will be available in the fall of 2000.
FY 2001 Target: To be developed.
Data Source/Validity of Data: Data will be reported by States indicating sources within states.
Date expected: December 2000.

Measure 2: Develop and implement performance and outcome measures for the SAPT block grant (see also Goal 4: TOPPS)

Rationale: The identification of performance and outcome measures for both the mental health and substance abuse block grant programs has been identified as a critical need. However, because the reporting of outcome information cannot be mandated for the block grant, the identification and acceptance of the outcome measures must be accomplished through a collaborative partnership. Such an approach requires time to implement and complete; the Treatment Outcome Pilot Projects (TOPPS) and other activities are in place to accomplish this goal. Targets in this area will, of necessity, be qualitative until a set of measures is developed and accepted by the states. After that, performance will be measured by the proportion of states submitting outcome data.

FY 1997 baseline	FY 1998 Target	FY 1998 actual	FY 1999 Target	FY 2000 Target
0 outcome measures tested; preliminary discussions held	Outcome domains selected; instrument selection underway	General agreement on domains has been reached with the states; work is continuing	Instruments will be selected and pilot-testing begun in selected states.	Initial data will be collected and analyzed; reliability and validity will be assessed in the participating states.

Data Source/Validity of Data: Ultimately, each State will determine how the information is to be collected and analyzed. As with earlier performance indicators, States will report this information in the applications and the reliability and validity will be assessed through project monitoring and periodic compliance reviews.

Progress to date: Initial TOPPS projects were funded at the end of FY 1997; TOPPS II projects were funded in September, 1998. Information domains and measures have been identified and instruments for data collection are being discussed.

Baseline: Baseline data will be available in FY 2000
FY 2000 Target: To be developed.

Data Source/Validity of Data: State Substance Abuse systems will collect this data each year. Data accuracy will be assessed in the TOPPS II projects (see Goal 4).

Date Expected: December 2000

Measure 3: Increase proportion of States that express satisfaction with technical assistance provided.

Rationale: Customer satisfaction is a good measure of the responsiveness and utility of SAMHSA=s information and technical assistance efforts. A global satisfaction measure that includes these components is being developed and will be used in future years.

FY 1998 (to date)	FY 1999 Target	FY 2000 Target
See below	TBD	TBD

Data Source/Validity of Data: Data source will be a survey of the States. Reliability and validity will be assessed when the survey is developed.

Progress to date: A customer feedback system was designed and piloted with 14 States in FY 1998. Expressions of satisfaction, via informal telephone interviews conducted by staff of an independent contractor, indicated a very high degree of satisfaction with the technical assistance provided and also suggested some improvements. Based upon this feedback, setting the FY 1999 and FY 2000 target at 85% is reasonable.

Measure 4: Increase proportion of TA events that result in appropriate systems, program, and/or practice change(s).

Rationale: The impact of technical assistance should be measured by changes that occur (or are maintained) in those systems, programs or practices which were addressed during the course of the technical assistance activity. Technical

assistance which is off-point, too esoteric for implementation, or otherwise not practical and applicable will not result in lasting improvements in the treatment system.

FY 1998 Target	FY 1998 actual (to date)	FY 1999 Target	FY 2000 Target
See below	See below	Baseline assessment	Will be set later

Data Source/Validity of Data: Data sources which are consonant with the selected measures will be selected and the validity and quality of data available will be ascertained as part of the selection process.

Progress to date: SAMHSA, in partnership with the field, began developing appropriate measures and data sources for this activity in FY 1998 (see discussion of Theme 2 earlier) as well as a methodology to ensure that the data are gathered without significant delay or burden to the recipients of TA. With regard to the SAPT BG, a system for ongoing feedback on the impact of CSAT technical assistance resources on State systems is under development. A component of that effort will be follow-up several months after the delivery of technical assistance to determine impact. This system will generate data compatible with that developed in the SAMHSA-wide effort related to Theme 2. Targets will be set once the baseline is known--sometime in FY 1999.

b. Targeted Capacity Expansion

This program addresses gaps in treatment capacity by supporting rapid and strategic responses to demand for alcohol and drug abuse treatment services.

Progress Report: This activity was funded for the first time in September, 1998. Each grantee in the program will be expected to report regularly on the number of clients served, the services provided, and the outcomes of those services. The grantees will also be required to compare this data to their estimates of the need for services and to demonstrate that they were having the expected impact on the need for services. Data on the estimated numbers of clients to be served will be reported in next year's report with data on the extent to which projects met those projections in the following year.

Measure 1: Proportion of estimated clients to be served /actually served

Rationale: This activity is intended to help communities meet unmet needs for substance abuse treatment services. The extent to which they meet those needs is one measure of the success of this program.

Baseline: Estimated numbers to be served will be available next year; a baseline will be provided the following year and a target set.

Target: To be determined.

Measure 2: Standard SAMHSA core outcome measures

Goal 1: Bridge the gap between knowledge and practice

Knowledge Development activities yield new information that can be used by the substance abuse treatment field to improve the efficiency or effectiveness of substance abuse treatment. The critical outcome of these activities is that knowledge is generated and that it is potentially useful.

a. Treating Adult Marijuana Users

Goal: This study is designed to enhance knowledge about treating adult abusers of marijuana - the most widely used and abused illicit substance in the United States. This study builds on previously executed clinical trials, the target population of which was predominantly male, white, and middle-class, and seeks to expand the knowledge base by determining whether or not the same brief intervention could be effective among those sub-populations that are typically found in public sector treatment facilities --i.e., both male and female, mostly minority, typically under-educated and either unemployed or under-employed.

Progress Report: The end of treatment evaluation and the 4-month evaluation have been completed. The 9-month follow-up has recently been initiated. A 12- to 15-month follow-up evaluation will be initiated in several months based on CSAT providing a small supplement. At this point this latter evaluation will be abbreviated and via telephone. It should be noted that outcomes of the Waiting List group are only determined at the 4-month follow-up evaluation.

Measure 1: Coordinating Center will submit copies of the two clinical intervention manuals, with annotations of Alessons learned@ during the conduct of the field portion of this project.

Rationale: In addition to generating findings on the relative effectiveness (or lack thereof) of brief interventions on marijuana users, this project expects to generate one or more intervention models that can be disseminated to clinicians throughout the country (assuming that the findings are in the predicted positive direction). Two intervention manuals, and associated annotations, will be delivered. These products will be reviewed as candidates for national dissemination, expanded clinical training, and further evaluation of the impact that brief interventions might have in addressing critical treatment needs.

FY 1998 Baseline: No manuals.
FY 1999 Target: A document will be developed by September 1999.

Data Source/Validity of Data: Project records will document activities of the Coordinating Center.

Progress report: Manuals were completed in August, 1998. They are being reviewed and dissemination plans developed. Completion of this activity was accomplished ahead of schedule and will be dropped in future report.

Measure 2 (new FY 2000): Across subpopulations, clients provided 12 weeks of treatment will have better outcomes than those provided 6 weeks of treatment.

Rationale: As indicated above, the previous research in this area indicates that 12 weeks of treatment has better results than 6 weeks but the individuals involved in those studies did not include large number of minority or female clients. Once completed, this study will provide evidence of effectiveness across a number of important subpopulations.

FY 1998 Baseline: Baseline, end-of-treatment, and 4 month data collection have been completed but not analyzed yet.
Target: To be determined.

Data Source/Validity of Data: Data is being collected with standard instruments administered to the clients by trained interviewers.

Progress report: Interim findings should be available for next year=s report.

b. Wraparound Services for Clients in Non-residential Substance Abuse Treatment Programs: Evaluating Utility and Cost effectiveness in the Context of Changes in Health Care Financing.

Goal: This study is designed to enhance knowledge about the effects on treatment outcomes from non-residential substance abuse treatment due to provision of wrap around services (e.g., child care, advisory legal services,

transportation, vocational training, educational services). If outcomes can be shown to be demonstrably improved when needs for wrap around services are met **C** in addition to the fundamental need for substance abuse treatment **C** and if those services can also be shown to be cost-effective, then the treatment field will have credible evidence with which to negotiate for the provision of those services through managed care architectures.

Progress Report: While the data collection is still underway, some preliminary information is available.

- The most frequently used wrap-around services used were transportation, educational services, and mental health services.

- The individuals who used the wraparound services tended to be single (36.7%), male (55%), Caucasian (66.1% vs 30.9% African American) and high school graduates (78.9%). 53% had some criminal justice involvement and 58.2% had income from wages.

- Predictors of acute problems from alcohol include insurance/payor difficulties, housing needs, and education needs.

- Contrary to belief in a dual system (public and private), there are seven subsystems with little interaction: private client, employed, insured; public client, poor, without insurance; active duty military and dependents; veterans; incarcerated; community-based with criminal justice status; and other (e.g., Native Americans, rural clients).

- Some initial assumptions changed during the study: (1) The Atreatment system@ is more an uncoordinated collection of providers; (2) The 2-tiered system of care (above) is actually a multi-tiered collection of providers serving different populations; and (3) The Aservice system@ is actually a web of interagency relationships.

- Examples of barriers include: (1) County level: interagency isolation, competition for clients and resources; agency bias against substance abuse clients; reluctance of rural counties to spend scarce county money Aout of county@ for services; (2) Program level: lack of knowledge of available services; inadequate services needs assessment; productivity emphasis discourages referral activities; long waits for services; and paperwork; services office-based, creating accessibility barriers; and (3) Client level: low client cognitive capacity and tolerance of paperwork; inability to focus on service-related needs in early recovery phase; crisis orientation; resentment at multiple assessments; perceived discrimination; lack of necessary conditions for service access (e.g., transportation); independent attitude and pride; need for external pressure for motivation.

Analyses will be continuing over the next year.

Measure 1 (FY 1999): Coordinating Center will develop and apply statistical models.

Rationale: The overarching goal of the program depends on the development of appropriate statistical models which are then applied to the clinical and programmatic databases.

FY 1998 Baseline: New project; not applicable.
Data Source/Validity of Data: Project records will document progress of statistical work.

Progress Report: Statistical model development is scheduled for completion no later than 30 June 1999. Application of models for core study questions will be completed no later than 30 September 1999. This measure will be dropped once completed.

Measure 2: 100% of final reports with findings, documented databases, and statistical models are transmitted to CSAT, and the results are validated by objective review.

Rationale: Credible scientific findings must be able to withstand scrutiny by external experts who are familiar not only with the theoretical bases of the research but who are also able to independently validate the conclusions drawn by that research.

FY 1998 Baseline: New project; not applicable.
Data Source/Validity of Data: Project records will document progress.

Progress report: Data collection is complete; data bases are partially documented; complete final report is to be submitted to CSAT no later than 30 September 1999. This measure will be replaced in the future by the Theme 1 crosscutting measure defined earlier and will be reported on in the FY 2001 GPRA performance report.

Measure 3: Clients receiving wrap-around services will have better outcomes than clients who receive substance abuse treatment alone (new FY 2000).

FY 1999 Baseline: Until baseline data collection is completed, no information is available.
Target: To be determined.
Data Source/Validity of Data: Data collection with standard instruments administered to the clients by trained interviewers has just been completed.

Progress report: Baseline data should be available for next year's report.

c. Treating Teen Marijuana Users

Measure 1: Clients treated with all five models will have significantly reduced marijuana use but none of the treatment will be more effective than the others.

Rationale: As indicated above, the previous research in this area indicates that all five interventions should be effective but only little evidence of their relative effectiveness exists.

FY 1999 Baseline: Until baseline data collection is completed in FY 1999, no information is available.

Target: To be determined.

Data Source/Validity of Data: Data will be collected with standard instruments administered to the clients by trained interviewers.

Progress report: Baseline data should be available for next year's report.

d. Starting Early, Starting Smart (with CMHS and CSAP)

Starting Early, Starting Smart, a SAMHSA-wide program, is developing and testing a comprehensive approach for at-risk families and children. In addition to the measures reported in the CSAP portion of the GPRA plan for this activity, CSAT is tracking the following measures:

Measure 1: All members of families who are identified as substance abusers will be offered treatment.

Rationale: One of critical risk factors for later substance abuse in children is substance abuse in the family.

FY 1999 Baseline: Per the CSAP description, data collection should begin shortly and will not be available until baseline data collection is completed.

Target: To be determined.

Data Source/Validity of Data: Data will be collected with standard instruments administered to the clients by trained interviewers.

Progress report: Some baseline data should be available for next year's report.

Measure 2: 50% of those family members provided substance abuse treatment will have reduced substance use at one year follow-up.

Rationale: Experience with a range of substance abuse treatment strategies suggests that 50% of those treated having reduced substance use is a reasonable target.

FY 1999 Baseline: Until baseline data collection is completed in FY 1999, no information is available.

Target: To be determined.
Data Source/Validity of Data: Data will be collected with standard instruments administered to the clients by trained interviewers.

Progress report: Follow-up data will not be available before FY 2001.

Goal 2: Promote the adoption of best practices

a. Addiction Technology Transfer Centers

The Addiction Technology Transfer Centers (ATTCs) are a critical component of CSAT's overall strategy for promoting the adoption of best practices in substance abuse treatment. Created in FY 1993, the original ATTCs included 11 geographically dispersed grantees covering 24 States and Puerto Rico who received their final funding in FY 1997. CSAT funded a new set of 14 grantees in September, 1998 to continue this important work in a more comprehensive and integrated way.

Measure 1: After an initial start-up phase, maintain training at 12,000 individuals per year

Rationale: Historically, the ATTCS have been able to provide training to approximately 12,000 individuals each fiscal year. Given that substance abuse treatment professionals trained in the best treatment strategies available should provide more effective treatment, improving the skills of substance abuse professionals should improve the overall effectiveness of treatment.

Baseline: In FY 1997, 12,000 individuals received training from the ATTCS.

Target: Because of start-up time, the FY 1999 target is 9,000 individuals. In FY 2000, 12,000 individuals will be trained.

Measure 2: Develop and implement nationally recognized standards for education and training for substance abuse treatment professionals (ONDCP Target 3.4.1)

Rationale: Adopting uniform standards based on best practices will assure that all clients have access to well trained, effective substance abuse professionals.

Baseline: No States.

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Target: All states will have adopted standards by FY 2002.

Progress Report: New activity

Goal 4: Enhance Service System Performance

a. State Needs Assessment and Resource Allocation Program

Progress Report: 40 states currently have contracts from CSAT to conduct needs assessment studies in support of their block grant planning and reporting; 23 of those states have successfully completed one round of studies and are conducting a second set at this time. The success of this ongoing program is reflected in the state=s ability to provide the data required by the statute.

Measure: Proportion of BG applications which include needs assessment data from CSAT needs assessment program.

Rationale: One of the statutory requirements for the SAPT block grant is that states base their planning for the use of BG funds on needs assessments within the state. For the past five years, CSAT has provided direct technical assistance (in dollars and personnel) to single state agencies to engage in state-based needs assessment activities. The block grant application requires that states be able to array need-for-treatment data using sub-state planning regions as the basic unit of analysis. Every state, and most territories have now received at least one award in this area, and each state which has completed a core of basic studies is encouraged to use those state-generated data sets as the basis of their block grant applications. A measure of the success of this activity is the proportion of states that do include this information; targets are based on the proportion of states who should have completed at least an initial round of needs assessment studies.

FY 1998 Target	FY 1998 actual	FY 1999 Target	FY 2000 Target
42%	57%	65%	65%

Data Source/Validity of Data: Data will be collected via the Block Grant Application System. Validity of the data under this system is reviewed as part of the approval of funding. In addition, reviews of the data are done as part of a cyclical compliance review process required by statute.

Progress Report: The proportion of states that submitted needs assessment data as part of their applications exceeded the FY 1998 target. In the coming year, CSAT will continue to work collaboratively with the States to increase the proportion of those who have completed their initial needs assessment studies to report that data in their applications.

b. Treatment Outcomes and Performance Pilot Studies

Progress Report: The activity was funded in September, 1998.

Measure 1: Reach agreement on the standardized approach within one year of funding.

Rationale: This collaborative program between the States and CSAT will develop a standardized approach that can be used across States to monitor the outcomes of substance abuse treatment in block grant funded providers. The development of a standardized approach is the first step in the process.

FY 1998 Baseline: Agreement on domains.

Target: Standardized approach to be developed by September, 1999.

Data Source/Validity of Data: Project records will document the agreements.

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Measure 2: Number of states incorporating the standardized outcome measures into their SAPT Block Grant process

Rationale: As an infrastructure development activity, the goal is to develop an approach that is feasible and adoptable by all of the States. Complete adoption by all States will take some time but annual progress should be monitored.

FY 1999 Baseline: Until baseline data collection is completed in FY 1999, no information is available.

Target: Within one year following completion of the activity (FY 2001), eight States will have adopted the standardized approach.

Data Source/Validity of Data: Data will be collected by community-based providers using standard instruments administered to the clients by trained interviewers.

Office of Applied Studies

Projects

Goal 4: Enhance service system performance

a. Expanded National Household Survey on Drug Abuse (NHSDA)

Goal: To provide estimates of the prevalence of substance abuse at the national level, and in the 50 States and the District of Columbia.

Program Update: A contract was awarded in FY 1998, which will ensure the availability of a data collection system in calendar year 1999.

Measure 1: Availability of data collection system in calendar year 1999.

Rationale: The product of this initiative will be relevant, accurate data to be used as performance measures by the Office of National Drug Control Policy and other Federal and State agencies engaged in efforts to reduce substance abuse. This requires the availability of a data collection system.

FY 98 Baseline: New initiative.

Measure 2: Availability and timeliness of data in calendar year 2000.

Rationale: This will be measured in the number of months between close of the relevant time period for data collection and the availability of data in print and electronic form. The first data from the initiative will be collected in calendar 1999, and will be available in calendar 2000.

FY 98 Baseline: New initiative.

b. Drug Abuse Warning Network (DAWN)

Goal: To provide estimates of drug-related emergency department visits at the national level, and for 21 large metropolitan areas.

Measure: Availability and timeliness of data.

Rationale: This will be measured in the number of months between close of the relevant time period for data collection and the availability of data in print and electronic form. This measure will be taken annually, using FY 1998 as the baseline. Once a baseline is established, specific target goals will be determined.

c. Drug Abuse Services Information System (DASIS)

Goal: To provide information on the services available for substance abuse treatment in the United States, and on the characteristics of patients admitted to treatment.

Measure: Availability and timeliness of data.

Rationale: This will be measured in the number of months between close of the relevant time period for data collection and the availability of data in print and electronic form. This measure will be taken annually, using FY 1998 as the baseline. Once a baseline is established, specific target goals will be determined.

FY 98 baseline: Information for the baseline is not yet available.

Office of Managed Care, Office of the Administrator

Goal: Promote the availability of effective services to persons enrolled in managed care.

Measure 1: Publication of nine reports on managed mental health and substance abuse services

Rationale: As the nation's mental health and substance abuse prevention and treatment systems are being transformed by managed care, it is essential that SAMHSA track and report developments, problems, and successful projects so that successful experiments can be replicated and problems can be avoided. No authoritative, consolidated source of information exists in the Federal government or elsewhere that provides an easily accessible source of knowledge about utilization, costs, consumer and provider characteristics and outcomes from the myriad changes being introduced throughout the MH/SA field by managed care.

1998 Progress Update:

- An actuarial study of the costs of implementing mental health and substance abuse parity coverage at varying levels of intensity of management of care published April, 1998.
- Two evaluation studies published of legal issues in Medicaid managed behavioral health care contracts (April, 1997; April, 1998)
- One evaluation study of legal issues in contracts between managed care organizations and community-based mental health and substance abuse agencies (April, 1998)
- Six technical assistance publications have been published: (1) ethical issues for behavioral health care practitioners and organizations in a managed care environment; (2) risk management; (3) designing substance abuse and mental health capitation projects; (4) a guide for MH/SA providers in negotiating managed care contracts; (5) partners in change: a consumers: guide to managed care contracts; (6) a guide for providers of MH/SA services in managed care contracting.
- Two newsletters have been published from the SAMHSA managed care tracking project, and a summary of public managed care services in each State through July 1, 1998 is under Departmental clearance review.

Measure 2: Coalitions of community MH/SA agencies for consumers, families, and advocates for persons who are mentally ill or substance abusers, and for State and county MH/SA and Medicaid agencies will receive training on managed MH/SA issues that they have identified as priorities, and at least 80% will report satisfaction with the training and a commitment to use their new knowledge and skills.

Rationale: Learning from health care reforms needs to be shared, and skills taught to enable consumers, families, providers, MCOs, and purchasers to make best use of the new options that managed care makes available.

FY 1997 Baseline: Little systematic training is being done for MH/SA provider organizations, consumers and families, and joint training of State and county MH/SA and Medicaid officials; information regarding success of training is not available.

Data Source/Validity of Data: Satisfaction and commitment to use reports will be derived from a survey of participation in training offered to at least 15 state-wide coalitions of community MH/SA agencies; 15 national and state-wide coalitions of consumers, families, and advocates for persons who are mentally ill or substance abusers or who are at risk for these disorders; and all 50 State mental health, substance abuse, and Medicaid agencies.

1998 Progress Update:

- In 1998, SAMHSA and its Centers= Offices of Managed Care have cosponsored 6 training conferences with the Institute for Behavioral Health care. Participant evaluations of the utility of the training exceed 85% satisfied or highly satisfied.
- In June, 1998, SAMHSA is co-sponsoring two major training conferences with the Institute for Behavioral Health care: A criminal justice and managed care summit, and a summit on quality improvement and performance standards.
- Training on managed care procurement and contract monitoring for consumers, families, and advocates will be held in at least 20 States through 1998 using SAMHSA developed materials. A dissemination strategy has been developed that has included input from direct consumers and families who participated in developing the contracting guide.
- A series of 20 managed care training programs for State-wide coalitions of mental health and substance abuse agencies has been set up by SAMHSA that will work with the Legal Action Center and the National Council for Community Behavioral Health care.
- SAMHSA has scheduled four regional training programs on managed behavioral health care contracting for State MH/SA and Medicaid agencies and for County behavioral health officials through the summer and early fall, 1998.

Measure 3: In at least ten States with active public managed MH/SA systems, representatives of consumer and family organizations contacted by the SAMHSA Public Managed Care Monitoring and Tracking Project will report satisfaction with their involvement in MC procurement, contracting and monitoring.

Rationale: Consumers and family members have made very important contributions to Federal, State, and county MH/SA systems over the last decade. However, consumers and their advocates report being extremely frustrated by their lack of involvement in managed care systems and generally feel that their needs are not being well served. SAMHSA supports efforts to develop service systems that are responsive to the needs of consumers, and involve consumers in treatment decisions, and in program planning, decision making, and evaluation.

Baseline: Results of studies to date are not consistent.

Data Source/Validity of Data: The SAMHSA Public Managed Care Monitoring and Tracking Project will begin in FY 1998 to systematically assess consumer and family organization satisfaction with their participation in planning, implementing and monitoring MH/SA managed care.

1998 Progress Update:

- Intensive training was provided for consumer and family representatives who are involved in reviewing Arkansas Medicaid managed care proposals.
- Assessment of consumer/family involvement in children managed behavioral health care planning indicates general satisfaction in 4 of 10 States intensively studied.

Measure 4: Release of detailed managed MH/SA quality management and accreditation guidelines by SAMHSA, and use of these guidelines by at least half of the States negotiating Medicaid MH/SA managed care contracts.

Rationale: There is no agreed-upon standard for quality management of MH/SA managed care systems that the Federal government and States use. This is a problem identified in the GWU studies of Medicaid managed care contracts that may contribute to limited access, consumer grievances, and poor outcomes. NCQA, JCAHO, CARF, COA, and Federal purchasers (DOD, DVA, Medicare) are developing and testing MH/SA managed care accreditation and quality management guidelines.

Data Source/Validity of Data: The Public Managed Care Monitoring and Tracking Project will survey quality management and accreditation standards used by States. The annual GWU legal analysis of Medicaid MH/SA MC contracts will track inclusion of standards in RFPs, contracts, and contract amendments.

1998 Progress Update:

- The GWU review of Medicaid managed behavioral health care contracts current through the beginning of 1997 found little improvement from the baseline 1995 survey.
- SAMHSA actively participated with HCFA in developing Quality Improvement Standards for Managed Care (QISMC), which will be the accreditation standards for Medicare and Medicaid managed care. SAMHSA is jointly developing with HCFA implementation guidelines for QISMC and training programs for State officials and Peer Review Organizations. Training events will be scheduled starting January, 1999.
- The GWU review of Medicaid contracts current through 1998 will assess use of quality management standards. It is not expected that changes will be seen until the 1999 or 2000 surveys.